

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 09/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>175542</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>ADVANCED HEALTH CARE OF OVERLAND PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207</b>		
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F 000	INITIAL COMMENTS  The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00078397, #KS00082487, and #KS00088192.	F 000			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 19 residents in the sample. Based on observation, interview, and record review the facility failed to honor resident preferences for when to wake up in the morning for 3 of 3 resident's sampled for choices. (#93, #248, #262)  Findings Included:  Review of resident #93's signed physician order sheet dated 9/2/2015 documented the following diagnoses: pneumonia (inflammation of the lungs) and insomnia (difficulty sleeping).  Review of the admission MDS (Minimum Data Set) dated 9/7/2015 documented a BIMS (Brief Interview for Mental Status) score of 13, which indicated the resident had intact cognition. The resident required limited to extensive assistance of one staff with ADL's (activities of daily living).	F 242			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 242	<p>Continued From page 1</p> <p>Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 9/10/2015 documented the resident had decreased mobility and required assistance of one staff with ADL's.</p> <p>Review of the care plan dated 8/31/2015 lacked documentation regarding the resident preferences of when he/she wanted to get up in the mornings. The sleep pattern section of the care plan blank.</p> <p>Review of an activity assessment dated 9/7/2015 documented the resident preferred to get up at 9:00 A.M.</p> <p>During an observation on 09/17/2015 at 6:03 A.M. the resident laid in bed, covered with a blanket, eyes closed with the lights on. At 6:30 A.M. direct care staff P entered the resident's room and took the resident's vital signs. The resident told staff P he/she was tired. The resident asked staff P to turn off the lights. Staff P turned off the lights as he/she left the room.</p> <p>During an observation on 09/21/2015 at 6:07 A.M. direct care staff Q entered the resident's room, turned on lights, and took the resident's vital signs. Staff Q told the resident "I'll be back to get you up soon." The resident stated, "Not too soon" and staff Q replied he/she would return around 7:00 A.M. The resident requested he/she return later than 7:00 A.M. Staff Q left the room without turning off the lights. On 09/21/2015 at 6:13 A.M. the resident turned on the call light and requested staff turn off hi/her light. Staff responded and turned off the lights.</p> <p>During an observation on 09/21/2015 at 6:38 A.M. direct care staff Q entered the resident's room</p>	F 242			

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F 242	<p>Continued From page 2</p> <p>and told the resident he/she wanted him/her to toilet. The resident stated he/she did not need to toilet and staff replied, "Let's just try". Staff assisted the resident to the toilet and asked the resident, "Can I go ahead and get you dressed since you're already up." The resident replied, "It's early" and staff replied, "Well, I get up at 5". Staff assisted the resident with dressing and curled the resident's hair as he/she sat in a chair. At 7:07 A.M. the resident sat in his/her wheelchair, covered with a blanket, in front of the television in his/her room.</p> <p>During an interview on 09/16/2015 at 5:26 P.M. the resident stated he/she preferred to sleep until 8:00 A.M., but staff frequently came to his/her room at 6:00 A.M.</p> <p>During an interview on 09/17/2015 at 6:15 A.M. direct care staff W stated he/she was not aware why the lights were left on in the resident's room and night staff did not wake up residents to get them up for the day.</p> <p>During an interview on 09/17/2015 at 11:18 A.M. direct care staff S stated it was his/her morning routine to start taking vitals at 6:00 A.M.</p> <p>During an interview on 09/21/2015 at 10:32 A.M. direct care staff Q said the resident was hard to get up in the mornings and knew the resident wanted to sleep in late. Stated the resident's preference was to get up around 9:00 A.M.</p> <p>During an interview on 09/21/2015 at 12:39 P.M. licensed nursing staff H stated the admission nurse asked the resident when he/she preferred to get up in the morning. Staff H said residents were technically able to sleep in, but preferred the residents get up and be ready for therapy. Staff</p>	F 242			

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F 242	<p>Continued From page 3</p> <p>H said the resident did not like to get up for breakfast, but he/she would. Staff H said staff started vital signs at 6:00 A.M. and the resident did not mind because he/she just went back to sleep. Staff H said he/she needed vitals by 7:00 A.M. to give medications.</p> <p>During an interview on 09/21/2015 at 7:14 P.M. administrative nursing staff D stated the facility was moving towards open dining and liberalized medication administration to allow for preferences of wake up time. Staff D stated the facility staff should wait closer to the resident's preferred wake up time to get vital signs and the staff could contact the physician to request a change in medication times.</p> <p>Review of the facility's undated Patient Directed Care policy documented the facility allowed resident's to direct their care to the extent possible.</p> <p>The facility failed to honor this resident's preferred wake up time.</p> <p>- Review of resident #248's signed physician order sheet dated 9/1/2015 documented the following diagnosis: hip replacement.</p> <p>Review of the admission MDS (Minimum Data Set) dated 9/4/2015 documented a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. The resident required extensive assistance of one staff with bed mobility, transfers, and toileting.</p> <p>Review of the ADL (activities of daily living) CAA</p>	F 242			

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F 242	<p>Continued From page 4</p> <p>(Care Area Assessment) dated 9/9/2015 documented the resident required assistance with ADL's following a left hip replacement.</p> <p>Review of the care plan dated 8/28/2015 documented the resident preferred to get up early and go to bed early. The options for the times on the care plan were for staff to mark early or late.</p> <p>Review of an activity assessment dated 9/2/2015 documented the resident preferred to get up at 8:00 A.M.</p> <p>During an observation on 09/17/2015 at 7:01 A.M. direct care staff S entered the resident's room to take vital signs. At 7:17 A.M. staff S returned to assist the resident with getting dressed. Staff S stated, "you need to think of how early I had to get up to come get you up".</p> <p>During an observation on 09/21/2015 at 7:40 A.M. direct care staff X assisted the resident with dressing.</p> <p>During an interview on 09/16/2015 at 5:53 P.M. the resident stated he/she preferred to sleep until 8:00 A.M.</p> <p>During an interview on 09/17/2015 at 7:06 A.M. the resident stated he/she did not want to get up now, however if he/she wanted breakfast before therapy came, he/she had to.</p> <p>During an interview on 09/21/2015 at 7:42 A.M. the resident sat on his/her bed getting dressed. The resident stated he/she preferred to get up at 8:00 A.M., "but they come in earlier".</p> <p>During an interview on 09/17/2015 at 11:18 A.M. direct care staff S said his/her morning routine</p>	F 242			

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F 242	<p>Continued From page 5</p> <p>was for him/her to obtain vitals at 6:00 A.M. Staff S was not aware of this resident's preference time for getting up in the morning.</p> <p>During an interview on 09/21/2015 at 10:47 A.M. direct care staff Q said he/she was not aware of the resident's preferred wake up time.</p> <p>During an interview on 09/21/2015 at 3:36 P.M. licensed nursing staff H stated the resident had no problem getting up early. He/she said once the staff started getting vital signs "you just get people up as you go." Stated the resident had no specific preference for when to get up in the morning.</p> <p>During an interview on 9/16/2015 at 7:48 A.M. therapy staff GG stated the therapy start times depended on when the therapist wanted to start. He/she stated the goal was to make sure therapy saw all residents and some therapist preferred to start early and some preferred to start later.</p> <p>During an interview on 09/21/2015 at 8:12 P.M. administrative nursing staff D stated he/she expected staff would not take vital signs until the resident's preferred time to get up at 8:00 A.M.</p> <p>Review of the facility's undated Patient Directed Care policy documented the facility allowed resident's to direct their care to the extent possible.</p> <p>The facility failed to honor this resident's preferred wake up time.</p> <p>- Review of resident #262's signed physician</p>	F 242			

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F 242	<p>Continued From page 6</p> <p>order sheet dated 9/14/2015 documented the following diagnoses: chronic obstructive pulmonary disease (chronic poor airflow in the lungs), hypertension (elevated blood pressure), and atrial fibrillation (an abnormal heart rhythm).</p> <p>There was not an MDS (Minimum Data Set) and CAA (Care Area Assessment) because the resident did not reside in the facility long enough to meet the criteria.</p> <p>Review of the care plan dated 9/11/2015 documented the resident's sleep pattern was to rise early and to go to bed early. The available options for the staff to mark times on the care plan were early and late.</p> <p>Review of the resident's activity assessment dated 9/14/2015 documented the resident preferred to wake up at 9:00 A.M.</p> <p>During an observation on 09/17/2015 at 7:24 A.M. licensed nursing staff K entered the resident's room to check the resident's blood sugar and give him/her insulin (a medication to control blood sugar levels).</p> <p>During an observation on 09/21/2015 at 7:33 A.M. licensed nursing staff L entered the resident's room to check his/her INR (International Normalized Ratio) (a test used to check how fast the blood can clot).</p> <p>During an interview on 09/16/2015 at 6:11 P.M. the resident stated staff woke him/her up for medications and he/she was not able to return to sleep. The resident said he/she preferred to take his/her medications later in the morning, but felt he/she had no choice.</p>	F 242			

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F 242	<p>Continued From page 7</p> <p>During an interview on 09/17/2015 at 11:18 A.M. direct care staff S said he/she obtained vitals at 6:00 A.M. per his/her normal routine. Staff S was not aware of this resident's preference time for getting up in the morning.</p> <p>During an interview on 09/21/2015 at 4:12 P.M. licensed nursing staff said the resident's preferred time to wake up was 7:00 A.M.</p> <p>During an interview on 09/21/2015 at 7:14 P.M. administrative nursing staff D stated the facility was moving towards open dining and liberalized medication administration to allow the residents to choose his/her wake up time. Staff D said he/she expected staff to wait closer to 9:00 A.M. to obtain vital signs, INR's, blood sugars, and to give medications.</p> <p>Review of the facility's undated Patient Directed Care policy documented the facility allowed residents to direct their care to the extent possible.</p> <p>The facility failed to honor this resident's preferred wake up time.</p>	F 242			
F 248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 19 residents in the sample. Based on observation, interview, and record review the</p>	F 248			

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F 248	<p>Continued From page 8</p> <p>facility failed to provide an activity program designed to meet the interest for 2 of 3 sampled residents reviewed for activities. (#4, #248)</p> <p>Findings Included:</p> <ul style="list-style-type: none"> <li>- Review of resident #4's signed physician order sheet dated 9/2/2015 documented the following diagnoses: traumatic upper arm fracture (broken bone)</li> </ul> <p>Review of the admission MDS (Minimum Data Set) dated 9/2/2015 documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The resident required extensive assistance of one staff with ambulation and locomotion on and off the unit. He/she reported it was very important for him/her to do things with groups of people.</p> <p>Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 9/8/2015 documented the resident required extensive with ADL's (activities of daily living)</p> <p>Review of the care plan dated 9/11/2015 failed to address the resident's activity preferences.</p> <p>Review of the August and September 2015 activity schedule documented the following scheduled weekend activities: Saturdays: 9:00 A.M. Daily Memo, 11:00 A.M. Sports Viewing or Games, 2:00 P.M. Movie or Games Sundays: 9:00 A.M. Daily Memo, 11:00 A.M. Sports Viewing</p>	F 248			

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F 248	<p>Continued From page 9</p> <p>Review of an activity participation record dated 8/27/2015 through 8/31/2015 documented the resident attended the following weekend activities: Daily memo activity and word game activity on 8/29/2015. The resident did not attend activities on 8/30/2015.</p> <p>Review of an activity participation record dated 9/1/2015 through 9/20/2015 documented the resident attended the following weekend activities: Daily memo activity and word game activity 9/12, 9/19, and 9/20/2015, word game activity on 9/12, 9/19, and 9/20/2015.</p> <p>During an observation on 09/17/2015 at 2:04 P.M. the resident worked with therapy in the therapy room.</p> <p>During an observation on 09/21/2015 at 6:21 A.M. the daily memo activity on the chalkboard placed by staff at the entrance of the therapy room read "Honey is the only food that does not go bad."</p> <p>During an interview on 09/17/2015 at 12:02 P.M. the resident stated there were not any activities that interested him/her on the weekends. The resident said he/she participated in activities during the week and would like to participate on the weekends if the facility offered them. The resident said he/she liked to socialize with others and was not interested in doing activities on his/her own. The resident said he/she arranged activities with other residents to keep busy and socialize, but would like the facility to hold activities.</p> <p>During an interview on 09/21/2015 at 1:52 P.M. the resident said he/she was not aware of what</p>	F 248			

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F 248	<p>Continued From page 10</p> <p>the daily memo activity was and he/she did not always read the chalkboard when entering the therapy gym. The resident said reading the chalkboard for an activity was not an activity of interest. The resident said his/her home caregiver brought in chips and dip to watch the football game last weekend, but was told the resident's were not able to use the therapy gym big screen television because the therapist were gone for the day. The resident said he/she never received crossword puzzles or word games and would not consider this an activity if it did not involve other people.</p> <p>During an interview on 09/17/2015 at 11:23 A.M. direct care staff S said activities began at 3:00 P.M. daily and resident would know about the activities by reading the screen located in the hallways or reading a calendar provided weekly. Staff S said the resident had access to board games and cards in the library room, as well as movies they could watch in their rooms.</p> <p>During an interview on 09/17/2015 at 2:46 P.M. direct care staff T said the facility had weekend movies in the therapy gym.</p> <p>During an interview on 09/21/2015 at 10:38 A.M. direct care staff Q said activities on the weekends included bible study and playing cards organized by the weekend receptionist or the CNA's (certified nursing assistants). Staff Q said most residents wanted to sleep on the weekends, but knew this resident liked to participated in activities on the weekends and during the week.</p> <p>During an interview on 09/21/2015 at 11:11 A.M. therapy staff HH stated he/she worked as an activity aide under the direction of the therapy director. He/she stated the activity calendar</p>	F 248			

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NAME OF PROVIDER OR SUPPLIER  <b>ADVANCED HEALTH CARE OF OVERLAND PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 248	<p>Continued From page 11</p> <p>schedule remained the same for more than one year. Staff HH said he/she tried to keep the activities the same because some residents had cognitive issues and did better with a structured calendar and it was easier to keep the activities the same. Staff HH said he/she came into the facility for 6 hours on one weekend day and the other weekend day the front desk receptionist was responsible for activities. Staff HH said staff wrote on the chalkboard a memo daily at the therapy entrance and residents who read it discuss it during therapy. He/she stated if the resident attended therapy, staff documented the resident attended the activity. Staff HH said if a resident liked to stay in his/her room, staff gave them crosswords for an individual activity. He/she stated, "I just hand it out" and if handed out the staff documented the resident attended the activity.</p> <p>During an interview on 09/21/2015 at 12:59 P.M. licensed nursing staff H stated this resident liked to play cards on the weekend with other residents.</p> <p>During an interview on 09/21/2015 at 7:42 P.M. administrative nursing staff D stated staff provided activities 7 days a week and should meet the individual resident preferences.</p> <p>During an interview on 09/21/2015 at 7:43 P.M. administrator A stated the weekend receptionist coordinated weekend activities and he/she worked from 9:00 to 5:00 P.M. Staff A said the nurses had a key to the therapy gym and could access the gym if a resident requested. Staff A said staff should provide group activities to the residents based on his/her preferences.</p> <p>Review of the Activity Program Policy dated</p>	F 248			

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F 248	<p>Continued From page 12</p> <p>1/10/2011 documented an ongoing activities program was designed to meet the individual interests and physical, mental, and psychosocial well-being of each patient and each month a calendar of events was designed to meet the individual interest and needs.</p> <p>The facility failed to provide group weekend activities to meet the interests of this resident.</p> <p>- Review of resident #248's signed physician order sheet dated 9/1/2015 documented the following diagnosis: hip replacement and depression (an abnormal emotional state characterized by feelings of sadness, worthlessness, emptiness and hopelessness).</p> <p>Review of the admission MDS (Minimum Data Set) dated 9/4/2015 documented a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. The resident required extensive assistance of one staff with walking and locomotion on and off the unit. He/she reported it was very important to him/her to do things with groups of people.</p> <p>Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 9/9/2015 documented the resident required assistance with ADL's following a left hip replacement.</p> <p>Review of the care plan dated 9/15/2015 failed to address the resident's personal preferences for activities.</p> <p>Review of the August and September 2015 activity schedule documented the following</p>	F 248			

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F 248	<p>Continued From page 13</p> <p>scheduled weekend activities.</p> <p>Saturdays: 9:00 A.M. Daily Memo, 11:00 A.M. Sports Viewing or Games, 2:00 P.M. Movie or Games</p> <p>Sundays: 9:00 A.M. Daily Memo, 11:00 A.M. Sports Viewing</p> <p>Review of the August and September 2015 activity schedule revealed there were no activities scheduled after 3:45 P.M. There were no activities scheduled in the evenings.</p> <p>Review of an activity participation record dated 8/29/2015 through 8/31/2015 documented the resident attended the following weekend activities: Daily memo and word games 8/29 and 8/30/2015. He/she did not attend any evening weekend activities.</p> <p>Review of an activity participation record dated 9/1/2015 through 9/20/2015 documented the resident attended the following weekend activities: Daily memo activity and word game activity 9/12, 9/19, and 9/20/2015, word game activity on 9/12, 9/19, and 9/20/2015. He/she did not attend any evening activities.</p> <p>During an observation on 09/16/2015 at 5:59 P.M. the resident laid in his/her bed visiting with a family member.</p> <p>During an observation on 09/21/2015 at 6:21 A.M. the daily memo activity on the chalkboard by staff at the entrance of the therapy room read "Honey is the only food that does not go bad."</p> <p>During an interview on 09/16/2015 at 5:49 P.M. the resident stated staff gave him/her an activity</p>	F 248			

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F 248	<p>Continued From page 14</p> <p>calendar when he/she first admitted and did not receive an activity calendar for the month of September. The resident said he/she would like to go to activities if activities were more convenient to attend and if he/she knew of evening and weekend activities.</p> <p>During an interview on 09/21/2015 at 1:50 P.M. the resident stated he/she was not aware of what the daily memo activity was and he/she did not receive word games.</p> <p>During an interview on 09/17/2015 at 11:23 A.M. direct care staff S said activities began at 3:00 P.M. daily and residents were to know about the activities by reading the screen located in the hallways or a calendar provided weekly. Staff S said the resident's have access to board games and cards in the library room, as well as movies they could watch in their rooms.</p> <p>During an interview on 09/17/2015 at 2:46 P.M. direct care staff T said the facility had weekend movies in the therapy gym.</p> <p>During an interview on 09/21/2015 at 10:38 A.M. direct care staff Q said activities on the weekends included bible study and playing cards organized by the weekend receptionist or the CNA's (certified nursing assistants). Staff Q said most residents wanted to sleep on the weekends, but knew this resident liked to participated in activities on the weekends and during the week.</p> <p>During an interview on 09/21/2015 at 11:11 A.M. therapy staff HH stated he/she worked as an activity aide under the direction of the therapy director. He/she stated the activity calendar schedule remained the same for more than one year. Staff HH said he/she tried to keep the</p>	F 248			

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F 248	<p>Continued From page 15</p> <p>activities the same because some residents had cognitive issues and did better with a structured calendar and it was easier to keep the activities the same. Staff HH said he/she came into the facility for 6 hours on one weekend day and the other weekend day the front desk receptionist was responsible for activities. Staff HH said the daily memo was a saying staff wrote on the chalkboard placed at the therapy entrance and residents who read it may discuss it when doing therapy. He/she stated if the resident attended therapy, staff documented the resident attended the activity. Staff HH said if a resident Stated liked to stay in his/her room, staff gave them crosswords for an individual activity. He/she stated, "I just hand it out" and if handed out the staff documented the resident attended the activity.</p> <p>During an interview on 09/21/2015 at 12:59 P.M. licensed nursing staff H stated he/she was not aware of the resident's activity preferences or activity involvement.</p> <p>During an interview on 09/21/2015 at 7:42 P.M. administrative nursing staff D stated the facility provided activities 7 days a week and they should meet the individual resident preferences. Staff D stated he/she considered activities scheduled at 3:00 P.M. were evening activities.</p> <p>During an interview on 09/21/2015 at 7:43 P.M. administrator A stated the weekend receptionist coordinated weekend activities and he/she worked from 9:00 to 5:00 P.M. Staff A said the nurses had a key to the therapy gym and could access the gym if a resident requested. Staff A said staff should provide activities to the residents based on his/her preferences.</p>	F 248			

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F 248	Continued From page 16 Review of the Activity Program Policy dated 1/10/2011 documented an ongoing activities program was designed to meet the individual interests and physical, mental, and psychosocial well-being of each patient and each month a calendar of events was designed to meet the individual interest and needs.  The facility failed to provide weekend and evening activities to meet the interests of this resident.	F 248			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 19 residents in the sample. Based on observation, interview, and record review the facility failed to develop a comprehensive care	F 279			

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F 279	<p>Continued From page 17 plan for 3 of 29 resident's reviewed. (#4, #248, #263)</p> <p>Findings Included:</p> <ul style="list-style-type: none"> <li>- Review of resident #4's signed physician order sheet dated 9/2/2015 documented the following diagnoses: traumatic upper arm fracture (broken bone)</li> </ul> <p>Review of the admission MDS (Minimum Data Set) dated 9/2/2015 documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The resident required extensive assistance of one staff with ambulation and locomotion on and off the unit. He/she reported it was very important for him/her to do things with groups of people.</p> <p>Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 9/8/2015 documented the resident required extensive with ADL's (activities of daily living)</p> <p>Review of the care plan dated 9/11/2015 failed to address the resident's activity preferences.</p> <p>Review of the August and September 2015 activity schedule documented the following scheduled weekend activities: Saturdays: 9:00 A.M. Daily Memo, 11:00 A.M. Sports Viewing or Games, 2:00 P.M. Movie or Games Sundays: 9:00 A.M. Daily Memo, 11:00 A.M. Sports Viewing</p> <p>Review of an activity participation record dated</p>	F 279			

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F 279	<p>Continued From page 18</p> <p>8/27/2015 through 8/31/2015 documented the resident attended the following weekend activities: Daily memo activity and word game activity on 8/29/2015. The resident did not attend activities on 8/30/2015.</p> <p>Review of an activity participation record dated 9/1/2015 through 9/20/2015 documented the resident attended the following weekend activities: Daily memo activity and word game activity 9/12, 9/19, and 9/20/2015, word game activity on 9/12, 9/19, and 9/20/2015.</p> <p>During an observation on 09/17/2015 at 2:04 P.M. the resident worked with therapy in the therapy room.</p> <p>During an observation on 09/21/2015 at 6:21 A.M. the daily memo activity on the chalkboard placed by staff at the entrance of the therapy room read "Honey is the only food that does not go bad."</p> <p>During an interview on 09/17/2015 at 12:02 P.M. the resident stated there were not any activities that interested him/her on the weekends. The resident said he/she participated in activities during the week and would like to participate on the weekends if the facility offered them. The resident said he/she liked to socialize with others and was not interested in doing activities on his/her own. The resident said he/she arranged activities with other residents to keep busy and socialize, but would like the facility to hold activities.</p> <p>During an interview on 09/21/2015 at 1:52 P.M. the resident said he/she was not aware of what the daily memo activity was and he/she did not</p>	F 279			

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F 279	<p>Continued From page 19</p> <p>always read the chalkboard when entering the therapy gym. The resident said reading the chalkboard for an activity was not an activity of interest. The resident said his/her home caregiver brought in chips and dip to watch the football game last weekend, but was told the residents were not able to use the therapy gym big screen television because the therapist were gone for the day. The resident said he/she never received crossword puzzles or word games and would not consider this an activity if it did not involve other people.</p> <p>During an interview on 09/17/2015 at 11:23 A.M. direct care staff S said activities began at 3:00 P.M. daily and resident would know about the activities by reading the screen located in the hallways or reading a calendar provided weekly. Staff S said the resident had access to board games and cards in the library room, as well as movies they could watch in their rooms.</p> <p>During an interview on 09/17/2015 at 2:46 P.M. direct care staff T said the facility had weekend movies in the therapy gym.</p> <p>During an interview on 09/21/2015 at 10:38 A.M. direct care staff Q said activities on the weekends included bible study and playing cards organized by the weekend receptionist or the CNA's (certified nursing assistants). Staff Q said most residents wanted to sleep on the weekends, but knew this resident liked to participate in activities on the weekends and during the week.</p> <p>During an interview on 09/21/2015 at 11:11 A.M. therapy staff HH stated he/she worked as an activity aide under the direction of the therapy director. He/she stated the activity calendar schedule remained the same for more than one</p>	F 279			

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F 279	<p>Continued From page 20</p> <p>year. Staff HH said he/she tried to keep the activities the same because some residents had cognitive issues and did better with a structured calendar and it was easier to keep the activities the same. Staff HH said he/she came into the facility for 6 hours on one weekend day and the other weekend day the front desk receptionist was responsible for activities. Staff HH said staff wrote on the chalkboard a memo daily at the therapy entrance and residents who read it discuss it during therapy. He/she stated if the resident attended therapy, staff documented the resident attended the activity. Staff HH said if a resident liked to stay in his/her room, staff gave them crosswords for an individual activity. He/she stated, "I just hand it out" and if handed out, the staff documented the resident attended the activity.</p> <p>During an interview on 09/21/2015 at 12:59 P.M. licensed nursing staff H stated this resident liked to play cards on the weekend with other residents.</p> <p>During an interview on 09/21/2015 at 7:42 P.M. administrative nursing staff D stated staff provided activities 7 days a week, meet the individual resident preferences, and be care planned.</p> <p>Review of the undated Comprehensive Care Plan Policy documented the facility developed a care plan to ensure the resident reached the highest practicable physical, mental, and psychosocial well-being.</p> <p>The facility failed to care plan individual activity preferences for this resident who wanted to participate in activities.</p>	F 279			

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F 279	<p>Continued From page 21</p> <p>- Review of resident #248's signed physician order sheet dated 9/1/2015 documented the following diagnosis: hip replacement and depression (an abnormal emotional state characterized by feelings of sadness, worthlessness, emptiness and hopelessness).</p> <p>Review of the admission MDS (Minimum Data Set) dated 9/4/2015 documented a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. The resident required extensive assistance of one staff with walking and locomotion on and off the unit. He/she reported it was very important to him/her to do things with groups of people.</p> <p>Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 9/9/2015 documented the resident required assistance with ADL's following a left hip replacement.</p> <p>Review of the care plan dated 9/15/2015 failed to address the resident's personal preferences for activities.</p> <p>Review of the August and September 2015 activity schedule documented the following scheduled weekend activities. Saturdays: 9:00 A.M. Daily Memo, 11:00 A.M. Sports Viewing or Games, 2:00 P.M. Movie or Games Sundays: 9:00 A.M. Daily Memo, 11:00 A.M. Sports Viewing</p> <p>Review of the August and September 2015 activity schedule revealed there were no activities scheduled after 3:45 P.M. There were no</p>	F 279			

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F 279	<p>Continued From page 22 activities scheduled in the evenings.</p> <p>Review of an activity participation record dated 8/29/2015 through 8/31/2015 documented the resident attended the following weekend activities: Daily memo and word games 8/29 and 8/30/2015. He/she did not attend any evening weekend activities.</p> <p>Review of an activity participation record dated 9/1/2015 through 9/20/2015 documented the resident attended the following weekend activities: Daily memo activity and word game activity 9/12, 9/19, and 9/20/2015, word game activity on 9/12, 9/19, and 9/20/2015. He/she did not attend any evening activities.</p> <p>During an observation on 09/16/2015 at 5:59 P.M. the resident laid in his/her bed visiting with a family member.</p> <p>During an observation on 09/21/2015 at 6:21 A.M. the daily memo activity written by staff on the chalkboard at the entrance of the therapy room read "Honey is the only food that does not go bad."</p> <p>During an interview on 09/16/2015 at 5:49 P.M. the resident stated staff gave him/her an activity calendar when he/she first admitted and he/she did not receive an activity calendar for the month of September. The resident said he/she would like to go to activities if activities were more convenient to attend and if he/she knew of evening and weekend activities.</p> <p>During an interview on 09/21/2015 at 1:50 P.M. the resident stated he/she was not aware of what</p>	F 279			

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F 279	<p>Continued From page 23</p> <p>the daily memo activity was and he/she did not receive word games.</p> <p>During an interview on 09/17/2015 at 11:23 A.M. direct care staff S said activities began at 3:00 P.M. daily and residents were to know about the activities by reading the screen located in the hallways or a calendar provided weekly. Staff S said the residents have access to board games and cards in the library room, as well as movies they could watch in their rooms.</p> <p>During an interview on 09/17/2015 at 2:46 P.M. direct care staff T said the facility had weekend movies in the therapy gym.</p> <p>During an interview on 09/21/2015 at 10:38 A.M. direct care staff Q said activities on the weekends included bible study and playing cards organized by the weekend receptionist or the CNA's (certified nursing assistants). Staff Q said most residents wanted to sleep on the weekends, but knew this resident liked to participate in activities on the weekends and during the week.</p> <p>During an interview on 09/21/2015 at 11:11 A.M. therapy staff HH stated he/she worked as an activity aide under the direction of the therapy director. He/she stated the activity calendar schedule remained the same for more than one year. Staff HH said he/she tried to keep the activities the same because some residents had cognitive issues and did better with a structured calendar and it was easier to keep the activities the same. Staff HH said he/she came into the facility for 6 hours on one weekend day and the other weekend day the front desk receptionist was responsible for activities. Staff HH said the daily memo was a saying staff wrote on the chalkboard placed at the therapy entrance and</p>	F 279			

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F 279	<p>Continued From page 24</p> <p>residents who read it may discuss it during therapy. He/she stated if the resident attended therapy, staff documented the resident attended the activity. Staff HH said if a resident liked to stay in his/her room, staff gave them crosswords for an individual activity. He/she stated, "I just hand it out" and if handed out the staff documented the resident attended the activity.</p> <p>During an interview on 09/21/2015 at 12:59 P.M. licensed nursing staff H stated he/she was not aware of the resident's activity preferences or activity involvement.</p> <p>During an interview on 09/21/2015 at 7:42 P.M. administrative nursing staff D stated the facility provided activities 7 days a week and they should meet the individual resident preferences. Staff D stated he/she considered activities scheduled at 3:00 P.M. were evening activities. Staff D said activity preferences should be care planned.</p> <p>Review of the undated Comprehensive Care Plan Policy documented the facility developed a care plan to ensure the resident reached the highest practicable physical, mental, and psychosocial well-being.</p> <p>The facility failed to care plan individual activity preferences for this resident who wanted to participate in activities.</p> <p>- Review of the closed record for resident #263's physician order sheet dated 8/8/2014 documented the following diagnoses: coronary artery disease (heart disease), anxiety (feelings of apprehension, uncertainty, and irrational fears), and depression (feelings of sadness, worthlessness, and emptiness).</p>	F 279			

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F 279	<p>Continued From page 25</p> <p>Review of the admission MDS (Minimum Data Set) dated 7/22/14 documented the resident had a BIMS (Brief Interview for Mental Status) score of 8, which indicated moderate cognitive impairment. The resident required physical assistance for bathing transfers and set up assistance with the bathing task.</p> <p>Review of the of ADL (Activities of Daily Living) documentation dated July 2014 through August 2014 recorded staff assisted the resident with one shower on 7/19/15 and the resident refused a shower on 7/30/15.</p> <p>During an interview on 9/17/2015 at 6:39 P.M. direct care staff Y stated he/she gave showers on the night shift if a resident requested, but staff did not shower residents per schedule on the night shift.</p> <p>During an interview on 9/21/2015 at 5:56 P.M. direct care staff V stated the facility scheduled residents for bathing twice a week, but they could have additional showers if requested. Staff V stated if a resident refused bathing, staff let the nurse know and then documented the refusal.</p> <p>During an interview on 9/21/2015 at 5:50 P.M. licensed nursing staff I stated residents received a shower twice a week and more often if he/she requested. Staff I said the CNA's (certified nursing assistants) gave the showers and he/she did not review the documentation. He/she asked the aides if the residents had showers and talked with the resident if they refused.</p> <p>During an interview on 9/21/2015 at 6:16 P.M. administrative nursing staff D stated staff should have showered the resident twice weekly and confirmed there was no documentation staff</p>	F 279			

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F 279	Continued From page 26 showered the resident and one documented refusal.  During an interview on 9/21/2015 administrative nursing staff D confirmed the care plan failed to address bathing.  Review of the undated Comprehensive Care Plan Policy documented the facility staff developed a care plan to ensure the resident reached the highest practicable physical, mental, and psychosocial well-being.  The facility failed to care plan bathing needs for this resident.	F 279			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 19 residents in the sample. Based on observation, interview, and record review the facility failed to provide the necessary care and services for 3 or 3 sampled residents reviewed for bruising. (#254, #259, #262)  Findings Included:	F 309			

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F 309	<p>Continued From page 27</p> <p>- Review of resident #254's signed physician order sheet dated 9/11/2015 documented the following diagnoses: aftercare following a knee replacement and edema (swelling).</p> <p>There were no MDS (Minimum Data Sets) and for CAAs (Care Area Assessments) for this resident because the resident's length of stay criteria was not met.</p> <p>Review of the care plan dated 9/8/2015 documented a skin tear to the resident's left arm, abrasions on his/her forehead and steri-strips to his/her left knee. Staff revised the care plan on 9/9/2015 and included edema. The care plan directed staff to apply a dressing to his/her left arm, Geri sleeves (fabric worn to protect skin from injury), ensure his/her heels were up when in bed, and tubigrips (elastic bandage support) to both lower legs.</p> <p>Review of a physician progress note dated 9/9/2015 documented the resident had a skin tear to his/her left arm and added a heel riser (a foam device used to elevate/offload) to offload the resident's heels.</p> <p>Review of physician orders documented the following: Geri sleeves to prevent further skin tears, 9/9/2015</p> <p>During an observation on 09/17/2015 at 7:58 A.M. the resident laid in bed with dark red and purple bruising observed to both arms and hands. The resident did not wear Geri sleeves and his/her heels were not elevated. The heel riser laid in the corner of the room.</p> <p>During an observation on 09/17/2015 at 9:23 A.M.</p>	F 309			

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F 309	<p>Continued From page 28</p> <p>the resident sat in his/her recliner and direct care staff Q assisted the resident with removal of his/her tubigrips and socks. The resident had bruising to the left inner heel. The resident did not wear Geri sleeves.</p> <p>During an observation on 09/17/2015 at 2:07 P.M. the resident laid in bed with his/her feet pressed against the footboard. The resident's heels were not elevated and he/she did not wear Geri-sleeves. The heel riser laid in the corner of the room</p> <p>During an observation on 09/21/2015 at 6:19 A.M. the resident laid in bed awake. The resident's heels were not elevated and he/she did not wear Geri-sleeves. The heel riser laid in the corner of the room.</p> <p>During an interview on 09/17/2015 8:00 A.M. the resident stated he/she had many bruises caused by an enlarged spleen. At 2:09 P.M. the resident stated he/she used his/her heel riser for the first time last night and staff did not instruct him/her to wear anything to protect his/her arms. The resident stated he/she was not aware what Geri-sleeves were.</p> <p>During an interview on 09/17/2015 at 9:26 A.M. direct care staff Q stated the resident had a heel riser he/she used at night to elevate the heels.</p> <p>During an interview on 09/17/2015 at 11:27 A.M. direct care staff S stated he/she unaware if the resident had bruising. Staff S stated current interventions to protect skin included the use of a heel rise to decrease swelling.</p> <p>During an interview on 09/21/2015 at 3:52 P.M. licensed nursing staff H stated the resident had</p>	F 309			

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F 309	<p>Continued From page 29</p> <p>bruising to both of his/her arms, a skin tear to his/her left forearm, a bruise to his/her left inner foot, and he/she wore Geri sleeves. Staff H reported the resident did not wear Geri sleeves today because of resident confusion and he/she was unaware if the resident used a heel riser in bed.</p> <p>During an interview on 09/21/2015 at 8:13 P.M. administrative nursing staff D said he/she expected staff to ensure the resident wore Geri sleeves and used a heel riser as ordered by the physician and care planned.</p> <p>Review of the undated Weekly Skin Report policy documented the nurse manager ensured the facility placed appropriate interventions were placed for healing.</p> <p>The facility failed to ensure the resident wore physician ordered Geri sleeves were and used a heel riser for this resident with bruising.</p> <p>- Review of resident #259's signed physician order sheet dated 9/15/2015 documented the following diagnoses: chronic obstructive pulmonary disease (poor airflow in the lungs)</p> <p>There was no MDS (Minimum Data Sets) or CAA's (Care Area Assessments) because the length of stay criteria was not met.</p> <p>Review of the care plan dated 9/14/2015 documented the resident had a skin tear on his/her left arm and bruising to his/her left and right upper and lower extremities. Staff revised</p>	F 309			

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F 309	<p>Continued From page 30</p> <p>the care plan on 9/15/2015 and directed staff the resident wore Geri sleeves (fabric worn to protect the skin) daily.</p> <p>During an observation on 9/17/2015 at 8:19 A.M. the resident sat in his/her recliner. He/she had dark scattered bruising to both of his/her arms and wore no Geri sleeves.</p> <p>During an observation on 09/17/2015 at 2:10 P.M. the resident sat in his/her recliner. He/she had scattered bruising to both of his/her arms and wore no Geri sleeves.</p> <p>During an interview on 09/17/2015 at 8:19 A.M. the resident stated medications caused him/her bruising. The resident stated he/she bruised easily and staff monitored labs.</p> <p>During an interview on 09/21/2015 at 2:18 P.M. the resident stated he/she did not have arm protectors and was unaware that he/she should wear them.</p> <p>During an interview on 09/17/2015 at 11:27 A. M. direct care staff S stated he/she was unaware if the resident had bruising or interventions to protect his/her skin.</p> <p>During an interview on 09/21/2015 at 10:53 P.M. care staff Q stated he/she was unaware of any skin issues or skin interventions for this resident.</p> <p>During an interview on 09/21/2015 at 4:07 P.M. licensed nursing staff H stated the resident had bruising to both arms and a skin to his/her left arm. Staff H reported the current interventions in place to protect the resident's skin included dressing changes and Geri sleeves. Staff H stated he/she was unaware if the resident had</p>	F 309			

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F 309	<p>Continued From page 31</p> <p>Geri sleeves. Staff H confirmed the resident did not wear Geri sleeves and asked the resident if he/she had Geri sleeves. The resident told the nurse he/she did not have Geri sleeves.</p> <p>During an interview on 09/21/2015 at 8:16 P.M. administrative nursing staff D stated he/she expected staff to ensure the resident wore Geri sleeves and stated it was the nurse's responsibility to ensure the sleeves were in place.</p> <p>Review of the undated Weekly Skin Report policy documented the nurse manager ensured the facility placed appropriate interventions were placed for healing.</p> <p>The facility failed to ensure the resident wore physician ordered Geri sleeves for this resident with bruising.</p> <p>- Review of resident #262's signed physician order sheet dated 9/14/2015 documented the following diagnoses: edema (swelling), diabetes mellitus (when the body could not use glucose, made enough insulin, or respond to the insulin), and cellulitis (a skin infection which may have redness, heat, and swelling caused by bacteria). There was no MDS (Minimum Data Set) or CAA's (Care Area Assessment) because the resident's length of stay criteria was not met.</p> <p>During an observation on 9/15/2015 at 1:59 P.M. the resident's had his/her lower pant leg pulled up and noted a small bluish quarter sized bruise to his/her left lower leg.</p> <p>During an observation on 09/17/2015 at 7:27 A.M.</p>	F 309			

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F 309	<p>Continued From page 32</p> <p>licensed nursing staff K and direct care staff S assisted the resident with a transfer from his/her bed to a bedside commode. Observation revealed two small quarter sized purple bruises to the resident's left lower leg.</p> <p>During an observation on 09/21/2015 at 4:21 P.M. the resident had two small quarter sized dark purple bruises to his/her left lower leg.</p> <p>During an interview on 09/16/2015 at 6:13 P.M. the resident stated he/she was not aware how the bruises to his/her leg occurred. The resident stated the facility checked his/her labs routinely since he/she took Coumadin (a blood thinner).</p> <p>During an interview on 09/17/2015 at 11:32 A.M. direct care staff S stated all nursing staff were not informed of medications, which could cause easy bruising, but were expected to notify the nurse if bruising occurred. Staff S was unaware of bruising on this resident.</p> <p>During an interview on 09/17/2015 at 2:53 P.M. direct care staff T stated he/she asked resident's if they had skin injury and if they did, he/she and would notify the nurse. Staff T was unaware of bruising on this resident.</p> <p>During an interview on 09/21/201 at 3:47 P.M. licensed nursing staff H stated the resident had edema and no skin issues on admission. Staff H stated the resident had the first skin assessment on 9/11/2015 with no bruising documented and a skin assessment on 9/18/2015 with no bruising documented. At 4:21 P.M. staff H confirmed the bruising to the resident's left lower leg.</p> <p>During an interview on 09/21/2015 at 8:18 P.M. administrative nursing staff D stated he/she</p>	F 309			

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F 309	Continued From page 33 expected staff to identify bruising during the skin assessment and to complete an incident report.  Review of an undated Weekly Skin Report Policy documented the nurse manager completed a weekly skin report on all residents with skin related conditions and ensured staff had appropriate interventions in place.  The facility failed to identify and follow up on bruising to this resident's left lower extremity during a weekly skin assessment.	F 309			
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE  Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.  This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 19 residents in the sample. Based on interview and record review the facility failed to provide the necessary bathing for 1 of 1 residents sampled and reviewed for bathing. (#263)  Finding Included:  Review of the closed record for resident #263's physician order sheet dated 8/8/2014 documented the following diagnoses: coronary	F 310			

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F 310	<p>Continued From page 34</p> <p>artery disease (heart disease), anxiety (feelings of apprehension, uncertainty, and irrational fears), and depression (feelings of sadness, worthlessness, and emptiness).</p> <p>Review of the admission MDS (Minimum Data Set) dated 7/22/14 documented the resident had a BIMS (Brief Interview for Mental Status) score of 8, which indicated moderate cognitive impairment. The resident required physical assistance for bathing transfers and set up assistance with the bathing task.</p> <p>Review of the of ADL (Activities of Daily Living) documentation dated July 2014 through August 2014 recorded staff assisted the resident with one shower on 7/19/15 and the resident refused a shower on 7/30/15.</p> <p>During an interview on 9/17/2015 at 6:39 P.M. direct care staff Y stated he/she gave showers on the night shift if a resident requested, but staff did not shower residents per schedule on the night shift.</p> <p>During an interview on 9/21/2015 at 5:56 P.M. direct care staff V stated the facility scheduled residents for bathing twice a week, but they could have additional showers if requested. Staff V stated if a resident refused bathing, staff let the nurse know and staff then documented the refusal.</p> <p>During an interview on 9/21/2015 at 5:50 P.M. licensed nursing staff I stated resident's received a shower twice a week and more often if he/she requested. Staff I said the CNA's (certified nursing assistants) gave the showers and he/she did not review the documentation. He/she asked the aides if the residents had showers and talked</p>	F 310			

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F 310	Continued From page 35 with the resident if they refused.  During an interview on 9/21/2015 at 6:16 P.M. administrative nursing staff D stated staff should have showered the resident twice weekly and confirmed thee was no documentation staff showered the resident and one documented refusal.  The facility failed to provide a bathing policy as requested.  The facility failed to ensure this cognitively impaired resident received adequate bathing.	F 310			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 19 residents in the sample. Based on observation, interview, and record review the facility failed to provide care and services to restore as much bladder function as possible for 1 of 1 resident's reviewed for incontinence. (#93)  Findings Included:	F 315			

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F 315	<p>Continued From page 36</p> <p>- Review of resident #93's signed physician order sheet dated 9/2/2015 documented the following diagnoses: recent hysterectomy (removal of the uterus, a female reproductive organ) and pneumonia (an inflammation of the lungs).</p> <p>Review of the admission MDS (Minimum Data Set) dated 9/7/2015 documented a BIMS (Brief Interview for Mental Status) score of 13, which indicated the resident had intact cognition. He/she did not reject cares. The resident required extensive assistance of one staff with bed mobility, transfers, and walking and limited assistance of one staff with toileting. The resident was frequently incontinent of urine and bowel and had no toileting program.</p> <p>Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 9/10/2015 documented the resident had decreased mobility following a hysterectomy and he/she required assistance of one staff with ADL's.</p> <p>Review of the Urinary Incontinence CAA dated 9/10/2015 documented the resident required assistance with toileting, had frequent urinary incontinence, a history of a prolapsed bladder (the bladder dropped down) and he/she notified staff for toileting needs.</p> <p>Review of the care plan dated 8/31/2015 documented the resident was incontinent and required assistance of one staff with toileting. The care plan directed staff to assist the resident with toileting upon rising, between meals, at bedtime, and as needed. Staff revised the care plan on 9/16/2015 following a fall and directed staff to assist the resident with toileting upon rising, between meals, and at bedtime.</p>	F 315			

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F 315	<p>Continued From page 37</p> <p>Review of a bowel and bladder assessment dated 9/3/2015 documented the resident was incontinent for years and voided 3-4 times a day. Staff were to assist the resident with toileting upon rising, before and after meals, and before bed.</p> <p>Review of the physician orders documented the following: Furosemide (a medication used to decrease swelling, which increased urine output) 20 mg (milligrams) by mouth daily for edema, 9/10/2015.</p> <p>During an observation on 09/16/2015 at 5:27 P.M. direct care staff O assisted the resident out of bed using extensive assistance and cued the resident to use his/her walker to transfer from the bed to the wheelchair. Staff assisted the resident to the dining room and failed to offer bathroom assistance.</p> <p>During an observation on 09/17/2015 at 8:01 A.M. staff P provided extensive assistance with standing and limited assistance with walking to the bathroom. The resident's brief was soiled and he/she smelled strongly of urine.</p> <p>During an observation on 09/21/2015 at 6:07 A.M. direct care staff Q entered the resident's room, turned on lights and took the resident's vital signs. Staff Q did not offer to assist the resident with toileting after he/she woke the resident.</p> <p>During an interview on 09/16/2015 at 5:16 P.M. the resident stated he/she slid out of bed twice when trying to take him/herself to the bathroom. The resident believed he/she turned on the call light both times for staff assistance and no staff came. The resident said the only times he/she</p>	F 315			

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F 315	<p>Continued From page 38</p> <p>attempted to walk by him/herself was to toilet when staff failed to respond to his/her call light. The resident stated the alarm was to let the staff know he/she needed to go to the bathroom.</p> <p>During an interview on 09/21/2015 at 1:47 P.M. the resident stated staff did not routinely assist the resident with toileting until he/she fell.</p> <p>During an interview on 09/17/2015 at 11:13 A.M. direct care staff S stated the resident was not on a toileting schedule.</p> <p>During an interview on 09/17/2015 at 2:36 P.M. direct care staff T stated the resident was continent of urine, used his/her call light for assistance as he/she needed, and was not on a set toileting schedule.</p> <p>During an interview on 9/21/2015 at 10:30 A.M. direct care staff Q stated staff checked on the resident every 2 hours and asked if he/she needed to toilet. Staff Q stated the resident was not on a specific toileting schedule so he/she asked about toileting every 2 hours and when the resident used his/her call light.</p> <p>During an interview on 09/21/2015 at 12:17 P.M. licensed nursing staff H stated the resident was on a toileting schedule upon rising, before meals, and bedtime, required a walker to ambulate and wore a brief for incontinence.</p> <p>During an interview on 09/21/2015 at 6:57 P.M. administrative nursing staff D stated he/she expected direct care staff to read the care plan to determine if a resident was on a toileting program. Staff D stated the standard toileting program for every incontinent resident was: upon rising, between meals, and at bedtime. Staff D</p>	F 315			

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F 315	Continued From page 39 stated the resident began a toileting schedule on 9/16/2015 following his/her fall. He/she was unsure if the resident was incontinent, but knew many falls occurred because of toileting needs.  Review of an undated bowel and bladder assessment documented facility staff would develop an individualized toileting plan for resident's with cognitive abilities and motivation to become continent.  The facility failed to provide a Urinary Incontinence Policy as requested.  The facility failed to assess and develop an individualized toileting plan for this cognitive resident with bladder incontinence.	F 315			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This Requirement is not met as evidenced by: The facility identified a census of 29 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to provide supervision to prevent falls for resident (#93) , failed to provide appropriate safety equipment for 2 residents (#248 and #255) all reviewed for accidents. The facility also failed to provided a safe and secure environment.	F 323			

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F 323	<p>Continued From page 40</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident #255 clinical record noted the resident had a diagnosis of right hip abscess. The resident was admitted to the facility 9/8/15.</li> </ul> <p>The impaired bed mobility care plan dated 9/9/15 noted the resident utilized lateral support bed canes on the left and right side of the bed. The staff educated the resident on the potential risks and benefits as well as the proper use of the above specified device. A safety assessment was preformed regarding the use of the bed canes and the resident demonstrated appropriate use of the bed canes. The bed canes were properly installed including the elimination of entrapment zones. The bed canes would be routinely assessed during cares for proper installation and positioning. Staff would promptly report concerns to the maintenance/therapy staff for immediate resolution.</p> <p>The physician's order dated 9/9/15 new order for bed canes for bed mobility.</p> <p>The physician's order dated 9/17/15 order for bed cane to left side of bed for mobility.</p> <p>The side rail consent form dated 9/9/15 listed potential benefits and potential risks and was signed by the resident for reason of increased independence with bed mobility.</p> <p>The side rail utilization assessment date 9/9/15 noted the resident used right and left bed canes.</p> <p>The side rail consent form dated 9/17/15 noted</p>	F 323			

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F 323	<p>Continued From page 41</p> <p>potential benefits, risks, and was signed by the resident for reason increased independence with bed mobility.</p> <p>The side rail utilization assessment dated 9/17/15 noted the resident used a left bed cane.</p> <p>On 9/15/2015 at 4:03 P.M. the resident's bed had bed canes on both sides of the bed. The left side bed cane had an opening of 11.5 inches by (x) 15 inches. The right side bed care had an opening of 11.5 inches x 11 inches. The resident stated he/she had to sign a form to be able to use the bed canes. The staff told him/her that he/she could be hurt using them. He/she did not have a problem with the rails and used them to help her get out of bed.</p> <p>On 9/16/2015 at 5:48 P.M. the resident laid in bed, had bed canes on both sides of bed.</p> <p>On 9/17/2015 at 7:55 A.M. the resident ambulated in his/her room independently with a front wheel. He/she sat down in the recliner. He/she stated he/she did not have his/her arm or leg tangled in the bed canes.</p> <p>On 9/16/2015 at 5:51 P.M. direct care staff U stated he/she the bed canes were used for bed mobility. The resident had a left bed cane.</p> <p>On 9/17/2015 at 8:05 A.M. direct care staff S stated resident #255 had right and left side bed canes. He/she had not seen a resident get a body part get stuck in them.</p> <p>On 9/21/15 at 5:56 P.M. direct care staff V stated the resident use the rail to help them turn in bed and be more independent.</p>	F 323			

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F 323	<p>Continued From page 42</p> <p>On 9/21/15 at 5:50 P.M. licensed staff I stated the resident used the bed can for mobility.</p> <p>On 9/17/15 at approximately 7:49 A.M. licensed staff DJ stated the residents had bed canes for mobility. Resident had the black bed canes with large openings on his/her bed.</p> <p>On 9/17/2015 at 8:15 A.M. administrative nursing staff D acknowledged resident #255 had bed canes both sides of bed with opening measurements of 11.5 x 10 inches on the left side, and opening of 12 x 15 inches on the right side.</p> <p>The facility failed to provide a policy for bed canes.</p> <p>The facility failed to provide safe bed canes for this resident.</p> <ul style="list-style-type: none"> <li>- Review of resident #93's signed physician order sheet dated 9/2/2015 documented the following diagnoses: recent hysterectomy (removal of the uterus) and pneumonia (an inflammation of the lungs).</li> </ul> <p>Review of the admission MDS (Minimum Data Set) dated 9/7/2015 documented a BIMS (Brief Interview for Mental Status) score of 13, which indicated the resident had intact cognition. He/she did not reject cares. The resident required extensive assistance of one staff with bed mobility, transfers, and walking and limited assistance of one staff with toileting. The resident required staff assistance to stabilize balance and used a walker and wheelchair for mobility. The resident was frequently incontinent of urine and bowel and had no toileting program. The resident experienced falls during the 1-6 months prior to his/her admission and had no</p>	F 323			

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F 323	<p>Continued From page 43 falls since admission.</p> <p>Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 9/10/2015 documented the resident had decreased mobility following a hysterectomy and he/she required assistance of one staff with ADL's.</p> <p>Review of the Urinary Incontinence CAA dated 9/10/2015 documented the resident required assistance with toileting, had frequent urinary incontinence, a history of a prolapsed bladder (the bladder drops down) and he/she notified staff for toileting needs.</p> <p>Review of the Falls CAA dated 9/10/2015 documented the resident had the following fall risk factors: impaired balance, reduced safety awareness, required assistance during transfers and ambulation, used antidepressant medication, and had a history of falls prior to his/her admission.</p> <p>Fall risk assessments documented the following scores: 8/31/2015- 10- no risk. 9/15/2015- 10- no risk. 9/16/2015- 12- fall risk.</p> <p>Review of the care plan dated 8/31/2015 documented the resident was at risk for falls due to weakness following a hysterectomy, was weight bearing as tolerated, used a wheelchair and walker with staff assistance. The resident's risk for falls was low and staff placed no interventions to prevent falls. The resident was incontinent and required assistance of one staff with toileting. The care plan directed staff to assist the resident with toileting upon rising, between meals, at bedtime, and as needed. Staff</p>	F 323			

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F 323	<p>Continued From page 44</p> <p>revised the care plan following a fall on 9/15/2015 and direct staff to add a bed alarm and fall mat. Staff revised the care plan on 9/16/2015 following a fall and directed staff to obtain an urinalysis to rule out infection, provide verbal education to the resident on the use of the call light, and assist the resident with toileting upon rising, between meals, and at bedtime.</p> <p>Review of a bowel and bladder assessment dated 9/3/2015 documented the resident was incontinent for years and voided 3-4 times a day. Staff were directed to assist the resident with toileting upon rising, before and after meals, and before bed.</p> <p>Review of a fall investigation dated 9/15/2015 documented the resident fell at 11:00 A.M. in his/her room when he/she attempted to put his/her phone back on the hook. Staff placed fall mats at bedside and bed alarms to prevent further falls. The investigation lacked details of where the phone was located in his/her room and when staff last saw the resident.</p> <p>Review of the fall investigation dated 9/16/2015 documented the resident fell at 7:45 A.M. in his/her room. Staff heard the bed alarm sound and found the resident seated on the floor mat beside his/her bed with the call light on. The resident reported he/she needed to use the toilet. Staff assisted the resident to the restroom and educated him/her to use the call light before getting out of bed. Additional interviews included: check urinalysis and add a toileting schedule.</p> <p>Review of physician orders documented the following: Furosemide/Lasix (a medication used to decrease swelling, which increased urine output)</p>	F 323			

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F 323	<p>Continued From page 45</p> <p>20 mg (milligrams) by mouth daily for edema, 9/10/2015</p> <p>During call light checks on 9/16/2015 at 1:30 P.M. the activate bedroom and bathroom call light did not transmit to the CNA (certified nursing assistant) pager system.</p> <p>During an observation on 09/16/2015 at 5:21 P.M. the resident laid in his/her bed, call light within reach, staff placed fall mats on both sides of his/her bed and placed a bed alarm under the sheets. At 5:27 P.M. direct care staff O assisted the resident out of bed using extensive assistance and cued the resident to use his/her walker to transfer from the bed to the wheelchair. Staff assisted the resident to the dining room and failed to offer bathroom assistance.</p> <p>During an observation on 09/17/2015 at 8:01 A.M. staff P provided extensive assistance with standing and limited assistance with walking to the bathroom. The resident's brief was soiled and he/she smelled strongly of urine.</p> <p>During an observation on 09/21/2015 at 6:07 A.M. direct care staff Q entered the resident's room, turned on lights and took the resident's vital signs. Staff Q did not offer to assist the resident with toileting after he/she woke the resident.</p> <p>During an interview on 09/16/2015 at 5:16 P.M. the resident stated he/she slid out of bed twice when trying to take him/herself to the bathroom. The resident believed he/she turned on the call light both times for staff assistance and no staff came. The resident said the only times he/she attempted to walk by him/herself was to toilet when staff failed to respond to his/her call light. The resident stated the alarm was to let the staff</p>	F 323			

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F 323	<p>Continued From page 46</p> <p>know he/she needed to go to the bathroom.</p> <p>During an interview on 09/21/2015 at 1:47 P.M. the resident stated staff did not routinely assist the resident with toileting until he/she fell.</p> <p>During an interview on 9/16/2015 at 1:35 P.M. direct care staff R stated the pagers did not always work and some call lights came through the pager while others did not. He/she stated when in the dining room or another resident room, he/she was not aware of which call lights came on.</p> <p>During an interview on 09/16/2015 at 5:30 P.M. direct care staff O stated the resident did not ask staff for help and experienced falls. Staff O stated he/she was made aware today the call light pagers were not working.</p> <p>During an interview on 09/17/2015 at 11:13 A.M. direct care staff S stated the resident had a risk for falls. Staff S said interventions to prevent falls included the use of fall mats and bed alarms. Staff S was unaware if the resident had falls since he/she admitted and stated the resident was not on a toileting schedule.</p> <p>During an interview on 09/17/2015 at 2:36 P.M. direct care staff T stated he/she knew the resident was a fall risk because the resident had a bed alarm and floor mats. Staff T stated the resident was continent or urine, used his/her call light for assistance as he/she needed, and was not on a set toileting schedule.</p> <p>During an interview 9/21/2015 at 10:30 A.M. direct care staff Q stated the resident was at risk for falls, used a bed and wheelchair alarm, and staff checked on the resident every 2 hours and</p>	F 323			

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F 323	<p>Continued From page 47</p> <p>asked if he/she needed to toilet. Staff Q stated the resident was not on a specific toileting schedule so he/she asked about toileting every 2 hours and when the resident used his/her call light. Staff Q stated he/she relied on the pager to answer resident call lights.</p> <p>During an interview on 09/21/2015 at 12:17 P.M. licensed nursing staff H stated the resident was on a toileting schedule upon rising, before meals, and bedtime, required a walker to ambulate and wore a brief for incontinence. Staff H said the resident slipped out of bed on 9/15/2015 and 9/16/2015. Staff H stated the risk factors for falls included: urinary urgency and poor cognition. He/she stated the physician discontinued the resident's Lasix on 9/21/2015. Staff H stated the resident required reminders to use the call light. Staff H reviewed the fall risk assessment dated 8/31/2015 and reported the resident was ambulatory with incontinence, which indicated the resident scored a 12 and had a risk for falls on admission. Staff H said direct care staff knew the resident's fall interventions by reviewing the CNA worksheet and/or care plan.</p> <p>During an interview on 09/21/2015 at 6:57 P.M. administrative nursing staff D stated he/she expected direct care staff to read the care plan to determine if a resident was on a toileting program. Staff D stated the standard toileting program for every incontinent resident was: upon rising, between meals, and at bedtime. Staff D stated he/she and licensed nursing staff H followed up with the resident following the fall on 9/15/2015 fall and determined the resident had attempted to reach his/her phone and not hand up the phone. Staff D stated he/she did not document findings. He/she confirmed the assessment lacked the location of the phone and</p>	F 323			

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F 323	<p>Continued From page 48</p> <p>when the staff last saw the resident. Stated the assessment should include the location of personal belongings and the phone. Staff D stated the resident began a toileting schedule on 9/16/2015 following his/her fall. He/she was unsure if the resident was incontinent, but knew a many falls occurred because of toileting needs. He/she stated the fall investigation report of 9/16 indicated the call light was activated.</p> <p>During an interview on 9/16/2015 at 1:43 P.M. administrator staff A stated there was no policy or system in place for checking to see if the call light pager system worked.</p> <p>Review of the Fall Prevention Policy dated 1/31/2011 documented the residents were evaluated on admission to determine fall risk and initiate appropriate interventions.</p> <p>The facility failed to ensure adequate assessment, supervision and assistance to prevent falls for this resident who required extensive staff assistance.</p> <p>- Review of resident #248's signed physician order sheet dated 9/1/2015 documented the following diagnosis: hip replacement</p> <p>Review of the admission MDS (Minimum Data Set) dated 9/4/2015 documented a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. The resident required extensive assistance of one staff with bed mobility and transfers.</p> <p>Review of the ADL CAA (Care Area Assessment)</p>	F 323			

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F 323	<p>Continued From page 49</p> <p>dated 9/9/2015 documented the resident required extensive assistance with bed mobility and transfers following a left hip replacement.</p> <p>Review of the resident's care plan dated 8/28/2015 documented the resident was at low risk for falls.</p> <p>Review of a side rail consent form signed by the resident on 9/1/2015 documented the resident consented to the usage of a bed cane to increase bed mobility independence. The potential benefits and risks included strangling, suffocating, bodily injury, and death when part of the body caught between rails or between the bed rails and mattress.</p> <p>During an observation on 9/16/2015 at 9:03 A.M. a bed cane measured 11 inches by 16 inches was on the left side of the bed.</p> <p>During an observation on 9/16/2015 at 5:59 P.M. the alert and oriented resident used the bed cane to change from a lying to a sitting position in bed with no safety issues observed.</p> <p>During an observation on 09/17/2015 at 7:17 A.M. the alert and oriented resident used the bed cane to change positions in his/her bed safely.</p> <p>During an interview on 09/21/2015 at 1:50 P.M. staff positioned a bed cane on the resident's left side of the bed with no large gaps observed.</p> <p>During an interview on 09/16/2015 at 5:46 P.M. the resident stated he/she asked for a bed cane because he/she felt safer. The resident said a therapist suggested the use of the bed cane and he/she found it helpful to get in and out of bed. The resident stated he/she had no problems or</p>	F 323			

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F 323	<p>Continued From page 50</p> <p>safety concerns with the use of the bed cane.</p> <p>During an interview on 09/17/2015 at 11:23 A.M. direct care staff S stated the resident used the bed cane appropriately and he/she had not witnessed safety concerns.</p> <p>During an interview on 09/17/2015 at 2:51 P.M. stated the resident used the bed cane safely.</p> <p>During an interview on 09/21/2015 at 3:32 P.M. licensed nursing staff H stated bed canes were for residents who needed help turning themselves in bed. Staff H stated bed canes were installed by therapy after completing an assessment.</p> <p>During an interview on 09/21/2015 at 7:59 P.M. administrative nursing staff D stated occupational therapy did an initial assessment for bed cane safety. He/she stated the facility did not consider gap measurements until brought to the facility's attention during the survey process.</p> <p>The Center for Devices and Radiological Health Guidance dated 3/2006 revealed that the Food Drug Administration recommended the greatest side rail gap to prevent head entrapment was 4.75 inches.</p> <p>The facility failed to ensure the environment remained as free from accident hazards as possible and installed an unsafe bed cane for resident #248's use.</p>	F 323			
F 329 SS=E	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or</p>	F 329			

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F 329	<p>Continued From page 51</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 19 residents in the sample. Based on observation, interview and record review the facility failed to identify and monitor potential adverse effects of black box warning medications for 3 of 5 resident's sample for unnecessary medications, (#4, #93, #242), failed to monitor bowel movements and provide treatment for 1 of 5 resident's sampled for unnecessary medications (#93), and failed to request physician ordered blood pressure parameters prior to withholding blood pressure medications for 2 of 5 resident's sampled for unnecessary medications. (#4, #259)</p> <p>Findings Included:</p>	F 329			

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F 329	<p>Continued From page 52</p> <p>Review of resident #4's signed physician order sheet dated 9/2/2015 documented the following diagnosis: hypertension (elevated blood pressure).</p> <p>Review of the admission MDS (Minimum Data Set) dated 9/2/2015 documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The resident 7 days of antianxiety, antidepressant, and diuretic medications during the 7 day observation period.</p> <p>Review of the Psychotropic Drug Use CAA (Care Area Assessment) dated 9/8/2015 documented the resident used antianxiety and antidepressant medications.</p> <p>Review of the care plan dated 9/11/2015 directed staff to administer medications as ordered by the physician. The care plan lacked identification and monitoring of black box warning medications.</p> <p>Review of a pharmacy consultant drug regimen review dated 9/3/2015 documented the clinical record was reviewed and there were no new suggestions.</p> <p>Review of the September 2015 MAR (medication administration record) documented staff held Lisinopril (a medication to treat high blood pressure) on 9/14/2015 and 9/15/2015.</p> <p>A review of physician ordered medications 8/26/2015 included the following medication orders: Cymbalta (a medication to treat depression) 60 mg (milligrams), give 120 mg by mouth daily for fibromyalgia (disease with chronic pain), effective</p>	F 329			

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F 329	<p>Continued From page 53</p> <p>8/26/2015</p> <p>Ferrous Sulfate (an iron supplement) 325 mg by mouth daily for anemia, effective 8/27/2015</p> <p>Hydrocodone-Acetaminophen (a narcotic pain medication) 5-325 mg by mouth every 4 hours as needed for pain scale of 1-5, give 2 tbs by mouth every 4 hours as needed for pain scale of 6-10, effective 8/26/2015</p> <p>Lisinopril 20 mg, give 40 mg by mouth BID for hypertension, effective 8/26/2015</p> <p>Lovenox (a medication used to prevent blood clots) 40 mg/0.4 ml (milliliter), give 40 mg subcutaneous daily for clot prevention, effective 9/13/2015</p> <p>Synthroid 150 mcg by mouth daily for hypothyroidism, effective 8/26/2015</p> <p>Trazodone (an antidepressant) 75 mg by mouth every bedtime for insomnia (inability to sleep), effective 9/9/2015</p> <p>During an observation on 09/17/2015 at 9:30 A.M. the alert and oriented resident sat in his/her electric wheelchair and worked with therapy.</p> <p>During an observation on 09/17/2015 at 4:32 P.M. the alert and oriented resident worked with therapy in the therapy room.</p> <p>During an interview on 09/21/2015 at 1:58 P.M. the resident said he/she was not aware if staff held his/her blood pressure medication, but he/she wanted staff to notify him/her "because I need to know that too". The resident stated he/she did not have negative effects from his/her medications.</p> <p>During an interview on 09/17/2015 at 11:21 A.M. direct care staff S stated direct care staff behaviors communicated behaviors verbally to the charge nurse. Staff S said CNA's (certified</p>	F 329			

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F 329	<p>Continued From page 54</p> <p>nursing assistants) documented bowel movements and vital signs. He/she said once vital signs were documented he/she gave the list to the charge nurse.</p> <p>During an interview on 09/17/2015 at 2:49 P.M. direct care staff T stated he/she was not aware if staff documented behaviors. He/she said if a resident experienced behaviors, he/she let the nurse know.</p> <p>During an interview on 09/21/2015 at 10:42 A.M. direct care staff Q said if a resident's blood pressure was more than 110/52, he/she let the nurse know immediately, otherwise he/she gave the vital sign flow sheet to the nurse once staff obtained all the vital signs.</p> <p>During an interview on 09/21/2015 at 1:04 P.M. licensed nursing staff H stated staff held blood pressure medications based on nursing judgement and the nurse notified the physician and the resident. Staff H confirmed nursing staff held Lisinopril on 9/14/2015 for a blood pressure of 117/67 and on 9/15/2015 for a blood pressure of 108/49. Staff H confirmed the medical record lacked documentation of physician or resident notification of blood pressure results and nurse's decision to hold Lisinopril. Staff H confirmed the care plan did not address black box warning medications.</p> <p>During an interview on 09/21/2015 at 7:54 P.M. administrative nursing staff D said he/she expected staff to hold blood pressure medication if the resident's systolic blood pressure (top blood pressure number) was less than 100 and the diastolic blood pressure result (bottom number of blood pressure) was not considered. Staff D</p>	F 329			

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F 329	<p>Continued From page 55</p> <p>expected staff to notify the resident and the physician if a nurse held a medication and expected the nurse to document the communication. Staff D expected black box warnings to be identified and monitored.</p> <p>Review of the facility's undated change in condition policy documented the facility staff promptly notified the physician of changes in a resident's medical condition and or status.</p> <p>The facility failed to identify and monitor warning medications for this resident with physician prescribed black box warning medications and failed to request parameters for holding this resident's physician prescribed blood pressure medication on 2 occasions.</p> <p>- Review of resident #93's signed physician order sheet dated 9/2/2015 documented the following diagnoses: pneumonia (inflammation of the lungs) and hypertension (elevated blood pressure).</p> <p>Review of the admission MDS (Minimum Data Set) dated 9/7/2015 documented a BIMS (Brief Interview for Mental Status) score of 13, which indicated the resident had intact cognition. The resident required limited assistance of one with toileting. The resident received 7 days of antidepressants and 7 days of antibiotic medication during the 7 day observation period.</p> <p>Review of the Psychotropic CAA (Care Area Assessment) dated 9/10/2015 documented the resident received antidepressant medication and staff were to monitor for signs/symptoms of side effects.</p>	F 329			

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F 329	<p>Continued From page 56</p> <p>Review of the care plan dated 8/31/2015 lacked documentation of black box warnings, behavior monitoring for medications effectiveness of antidepressant use. The resident had a risk for altered elimination and staff were directed to administer medications as ordered, keep an accurate record of bowel movements to avoid complications, and to assist to utilize the toilet as needed.</p> <p>Review of a pharmacist drug regimen review dated 9/3/2015 documented the resident should take Ibuprofen with food.</p> <p>Review of a bowel movement monitoring record dated 8/31/2015 to 9/20/2015 documented the resident had no bowel movements from 9/3/2015 through 9/8/2015.</p> <p>Review of the MAR (medication administration record) dated 9/3/2015 through 9/8/2015 documented the resident received no additional medications for bowel regulation.</p> <p>Review of nursing progress notes dated 9/3/2015 through 9/8/2015 documented the resident had a bowel movement on 9/6/2015.</p> <p>Review of physician orders included the following medications: Dulcolax (a medication to treat constipation) 10 mg suppository rectally daily as needed for bowel regulation, effective 9/3/2015 Oxycodone/Acetaminophen (a narcotic pain medication) 5-325 mg, give 2 tablets every 4 hours as needed for pain rated a 6-10, effective 8/31/2015</p> <p>During an observation on 09/16/2015 at 5:21</p>	F 329			

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F 329	<p>Continued From page 57</p> <p>P.M. the resident laid in his/her bed with eyes closed, lights out, and no signs of restlessness.</p> <p>During an interview on 09/16/2015 5:43:04 P.M. the resident stated he/she was aware of his/her medications, he/she received the same medication for some time, and had no negative effects from his/her medications.</p> <p>During an interview on 09/21/2015 at 1:45 P.M. the resident reported he/she experienced constipation since admission. The resident said he/she told staff and staff said they would give him/her medication to treat the constipation, but staff did not.</p> <p>During an interview on 09/17/2015 at 11:21 A.M. direct care staff S said staff monitored and documented bowel movements and vital signs daily.</p> <p>During an interview on 09/21/2015 at 10:36 A.M. direct care staff Q stated residents were asked in the mornings and later in the day when his/her last bowel movement occurred. Staff Q said staff documented bowel movements on the vital sign sheet and in the electronic record.</p> <p>During an interview on 09/21/2015 at 12:43 P.M. licensed nursing staff H stated the CNA's (certified nursing assistants) were to ask the residents when his/her last bowel movement was and document the bowel movements. He/she stated the nurse also documented in the progress notes if a resident had a bowel movement. Staff H said if a resident went 3 days without a bowel movement, the nurse administered Milk of Magnesia, if 4 days passed without a bowel movement, the nurse administered a Dulcolax Suppository, and if 5 days passed with no bowel</p>	F 329			

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F 329	<p>Continued From page 58</p> <p>movement, the nurse gave the resident an enema. Staff H confirmed the resident had no documented bowel movement from 9/3/2015 through 9/5/2015 and staff did not administer Milk of Magnesia. Staff H confirmed he/she was not aware of black box warning medications, said black box warning medications were not specific, and staff did not monitor potential negative effects for this resident.</p> <p>During an interview on 09/21/2015 at 7:23 P.M. administrative nursing staff D said he/she expected nurses and CNA's to document bowel movements. Staff D confirmed the resident had no documented bowel movement from 9/3/2015 through 9/5/2015 and said the staff failed to administer Milk of Magnesia to the resident on 9/5/2015. Staff D confirmed staff did not care plan or monitor black box warnings.</p> <p>Review of the facility's undated Bowel Brigade policy documented staff administered Milk of Magnesia 30 ml (milliliters) in the morning if the resident did not have a bowel movement for 3 days.</p> <p>The facility failed to provide a Black Box Warning Medication Policy as requested.</p> <p>The facility failed to treat this constipated resident after 3 days without a bowel movement and failed to identify and monitor physician ordered black box warning medications.</p> <p>- Review of resident #259's signed physician order sheet dated 9/15/2015 documented the following diagnoses: chronic obstructive pulmonary disease (chronic poor airflow in the lungs) and hypertension (elevated blood</p>	F 329			

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F 329	<p>Continued From page 59 pressure).</p> <p>The MDS (Minimum Data Set) or CAA (Care Area Assessment) were not completed because the length of stay criteria was not met.</p> <p>Review of the care plan dated 9/14/2015 revealed staff did not address medications.</p> <p>Review of the September 2015 MAR (medication administration record) documented the following: On 9/17/2015 Coreg 6.25 mg by mouth staff did not administer. Staff documented the resident's blood pressure was low at 109/67.</p> <p>On 9/19/2015 Coreg was held for a blood pressure of 99/62.</p> <p>Review of physician orders documented the following: Coreg 6.25 mg (milligrams) by mouth twice daily with meals for hypertension, effective 9/14/2015</p> <p>During an observation on 9/17/2015 at 11:35 A.M. the resident sat in his/her recliner. The resident was alert, oriented, and anxious about his/her medications.</p> <p>During an interview on 09/17/2015 at 8:11 A.M. the resident said staff failed to give him/her Coreg.</p> <p>During an interview on 09/21/2015 at 2:13 P.M. the resident stated the nurse told him/her on 9/18/2015 that his/her blood pressure ran low and the physician chose to hold the evening dose of Coreg .</p>	F 329			

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F 329	<p>Continued From page 60</p> <p>During an interview on 09/17/2015 at 11:21 A.M. direct care staff S said CNA's (certified nursing assistants) obtain and document vital signs. He/she said staff documented all the vital signs , he/she gave the list to the charge nurse.</p> <p>During an interview on 09/21/2015 at 10:42 A.M. direct care staff Q said if a resident's blood pressure was more than 110/52, he/she let the nurse know immediately, otherwise he/she gave the vital sign flow sheet to the nurse once staff took all vital signs.</p> <p>During an interview on 09/21/2015 at 3:57 P.M. licensed nursing staff H stated he/she informed residents when he/she held a medication and was not aware if this was a facility policy. Staff H said the nurse should notify the physician if a nurse held a medication. Staff H confirmed staff held the resident's Coreg on 9/17/2015 for a blood pressure of 109/67 and held it on 9/19/2015 for a blood pressure of 99/62. Staff H said different staff held blood pressure medications for different blood pressure results and confirmed the medical record lacked documentation of physician notification of blood pressure results, late administration of breathing treatments, and holding of blood pressure medication.</p> <p>During an interview on 09/21/2015 at 7:54 P.M. administrative nursing staff D said he/she expected staff to hold blood pressure medication if the resident's systolic blood pressure (top blood pressure number) was less than 100 and the diastolic blood pressure result (bottom blood pressure number) was not considered. Staff D expected staff to notify the physician if a nurse held a medication and expected the nurse to document the communication.</p>	F 329			

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F 329	<p>Continued From page 61</p> <p>Review of the facility's undated change in condition policy documented the facility staff promptly notified the physician of changes in a resident's medical condition and or status.</p> <p>The facility failed to request parameters for holding this resident with hypertension physician prescribed blood pressure medication on 2 occasions.</p> <p>- Review of resident #242's signed physician's orders dated 9/1/15 documented the following diagnoses: congestive heart failure (the heart cannot pump enough blood to meet the body's need) and depression (feelings of sadness, worthlessness, and emptiness).</p> <p>Review of the 14 day admission Minimum Data Set (MDS) dated 8/31/15 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident did not reject cares. The resident received scheduled pain medication, an antidepressant, and a diuretic for 7 of 7 days during the 7 day observation period.</p> <p>Review of the Psychotropic Drug Use Care Area Assessment (CAA) dated 9/1/15 documented review of the resident's medications revealed they met the resident's needs, and staff continued to give medications as ordered and monitored for adverse effects.</p> <p>Review of the care plan dated 8/19/15 directed staff to administer medications as ordered, monitor for pain, and notify the physician if the medication was not effective. Staff revised the care plan on 9/7/15 to address the resident's mood. The care plan directed staff to provide reassurance and support, monitor for withdrawal</p>	F 329			

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F 329	<p>Continued From page 62</p> <p>or increased depression, and to offer counseling services as needed. The resident was at risk for dehydration (not enough body water) due to medication use and staff to monitor labs as ordered and monitor for signs/symptoms of dehydration.</p> <p>Review of the resident's physician ordered medications included the following: Furosemide (medication to treat increased body fluid) 20 mg (milligrams), give 40 mg once daily by mouth for edema, effective 8/19/2015 Sertraline (antidepressant) 100 mg by mouth once daily for depression, effective 8/19/2015 Spironolactone (medication to treat increased body fluid) 25 mg once daily for congestive heart failure, effective 8/19/2015 Levaquin (antibiotic) 500 mg, give 2 tablets daily for infection, effective 9/4/2015</p> <p>During an observation on 9/16/15 at 3:30 P.M. the resident sat in his/her room calmly watching television.</p> <p>During an observation on 9/21/15 at 10:45 A.M. the resident sat in a recliner in his/her room. The resident was pleasant and cheerful.</p> <p>During an interview on 9/21/15 at 10:45 A.M. the resident stated he/she received his/her medications on time.</p> <p>During an interview on 9/21/15 at 2:09 P.M. licensed nursing staff H stated the resident had no behaviors, which required redirection. He/she said the resident received a medication for depression and was unaware of any other black box warning medications (high risk medications).</p> <p>During an interview on 9/21/15 at 6:51 PM</p>	F 329			

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F 329	Continued From page 63 licensed nursing staff M said the resident had no behaviors and he/she received 4 medications with black warnings and the warnings were in the narcotic book as of today.  During an interview on 9/21/2015 at 7:54 P.M. administrative nursing staff D said he/she expected staff to care plan and monitor black box warning medications.  The facility failed to provide a policy on Black Box Warning Medications as requested.  The facility failed to identify and monitor physician prescribed medications for this resident with black box warning medications.	F 329			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This Requirement is not met as evidenced by: The facility reported a census of 29 residents. Based on observation and interview the facility failed to distribute food under sanitary conditions in 1 of 1 kitchen for 2 of 4 observation days.  Findings Included:	F 371			

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F 371	<p>Continued From page 64</p> <p>During an observation on 9/16/2015 at 10:07 A.M. dining staff EE sliced vegetables in the kitchen with gloved hands, retrieved tuna and chicken salad from the walk in refrigerator, obtained bread loaves, touched menus, and with same gloved hands he/she handled the bread.</p> <p>During an observation on 9/21/2015 at 5:50 P.M. dining Staff FF twice handled bread with soiled gloves.</p> <p>During an interview on 9/16/2015 at 10:43 A.M. dining staff II stated he/she expected staff to not touch bread when making when sandwiches and when assisting resident other residents.</p> <p>The facility's Bare Hand Contact with Food and Use of Plastic Gloves policy dated 2013 documented staff need to change his/her gloves anytime staff touched a contaminated surface.</p> <p>The facility failed to distribute food in a sanitary manner.</p>	F 371			
F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p>	F 425			

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F 425	<p>Continued From page 65</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 19 residents in the sample. Based on observation, interview, and record review the facility failed to meet the medication needs for 2 sampled residents. (#258, #262)</p> <p>Findings Included:</p> <p>- Review of resident #262's signed physician order sheet dated 9/14/2015 documented the following diagnosis: diabetes mellitus (when the body could not use glucose, made enough insulin, or respond to the insulin).</p> <p>There were not MDS (Minimum Data Set) and CAA (Care Area Assessment) for this resident due to his/her length of stay in the facility.</p> <p>Review of the care plan dated 9/11/2015 documented the resident had diabetes and directed staff to administer medications as prescribed, monitor blood sugars as ordered, provide a bedtime snack, and monitor for signs/symptoms of hypo/hyperglycemia (low and/or high blood sugars).</p> <p>Review of physician orders documented the following: Novolog (rapid acting insulin) 16 units</p>	F 425			

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Printed: 09/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>175542</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/28/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>ADVANCED HEALTH CARE OF OVERLAND PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207</b>		
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F 425	<p>Continued From page 66</p> <p>subcutaneous daily between 7:00 A.M. to 9:00 A.M., effective 9/11/2015</p> <p>Novolog 12 units subcutaneous daily with lunch, effective 9/11/2015</p> <p>Novolog 15 units subcutaneous daily with dinner, effective 9/11/2015</p> <p>During an observation on 9/15/2015 at 12:36 P.M. staff served the resident a room tray. The resident told staff he/she had a sugar crash and ate an orange before staff delivered a tray. The resident stated he/she received insulin an hour ago at 11:40 A.M. Licensed nursing staff H returned to the resident's room at 12:39 P.M. and checked the resident's blood sugar. The resident's blood sugar was 88.</p> <p>During an observation on 09/17/2015 at 7:24 A.M. licensed nursing staff K entered the resident's room to check the resident's blood sugar and administer insulin. The resident's blood sugar was 250. Staff K administered insulin in the resident's abdomen at 7:31 A.M. Direct care staff S told the resident someone would return to serve him/her a room tray.</p> <p>During an interview on 09/17/2015 at 7:42 A.M. the resident stated his/her physician told him/her he/she should take Novolog Insulin immediately before eating. The resident said he/she experienced episodes of sweating with low blood sugar due to waiting for food once staff administered his/her insulin. The resident asked for something to tide him/her over until breakfast arrived and direct care staff brought him/her a Greek yogurt.</p> <p>During an observation on 09/17/2015 at 8:26 A.M. direct care staff S delivered the resident a room tray of muffins, an orange, and coffee.</p>	F 425			

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F 425	<p>Continued From page 67</p> <p>During an interview on 09/17/2015 7:39 A.M. direct care staff S stated staff served room trays after staff served the resident's in the dining room.</p> <p>During an interview on 09/21/2015 at 1:39 P.M. dietary staff DD stated staff served the residents in the dining room first and then prepared room trays. Staff DD reported it was up to nursing to determine when to give insulin and nursing staff did not communicate with dietary when a resident who received insulin needed a room tray.</p> <p>During an interview on 09/17/2015 at 8:31 A.M. licensed nursing staff K stated Novolog works within 15 minutes after administration and he/she expected staff to serve the resident's breakfast within 15 minutes. Staff K said staff delivered room trays after they served other residents in the dining room and he/she was not sure why the resident did not receive a breakfast tray within 15 minutes.</p> <p>During an interview on 09/21/2015 at 4:12 P.M. licensed nursing staff H stated the resident should eat within 30 minutes of insulin administration, but the resident liked the insulin with his/her first bite. Staff H said he/she was not sure how fast Novolog worked once administered. Staff H stated Novolog was ordered for staff to administer between 7 A.M. and 9 A.M., with lunch, and with dinner and was not aware why the breakfast insulin was not specified with meals.</p> <p>During an interview on 09/21/2015 at 6:37 P.M. administrative nursing staff D said he/she was not aware of how fast Novolog worked once administered. Staff D referred to a drug guide</p>	F 425			

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F 425	Continued From page 68 and stated the Novolog worked rapidly and recommended administration within 15 minutes before a meal or immediately following a meal. Staff D said he/she expected staff to ask for a clarifying order regarding administration time of the morning insulin. Staff D said he/she expected nursing staff to make sure the resident received a meal, not a snack, within 30 minutes of insulin administration.  The facility failed to provide an insulin administration guideline policy as requested.  The facility failed to ensure staff administered to this insulin dependent diabetic timely for the most effective control of his/her blood sugars.	F 425			
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.          This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 19 residents in the sample. Based on observation, interview and record review the pharmacy failed to monitor and make recommendations to the facility for the identification and monitoring of black box warning medications for 3 of 5 resident's sample for unnecessary medications, (#4, #93, #242), failed	F 428			

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F 428	<p>Continued From page 69</p> <p>to monitor and make recommendations for bowel irregularities for 1 of 5 resident's sampled for unnecessary medications (#93), and failed to monitor and make recommendations for blood pressure parameters related to facility staff withholding blood pressure medications for 2 of 5 resident's sampled for unnecessary medications. (#4, #259)</p> <p>Findings Included:</p> <p>Review of resident #4's signed physician order sheet dated 9/2/2015 documented the following diagnosis: hypertension (elevated blood pressure).</p> <p>Review of the admission MDS (Minimum Data Set) dated 9/2/2015 documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The resident 7 days of antianxiety, antidepressant, and diuretic medications during the 7 day observation period.</p> <p>Review of the Psychotropic Drug Use CAA (Care Area Assessment) dated 9/8/2015 documented the resident used antianxiety and antidepressant medications.</p> <p>Review of the care plan dated 9/11/2015 directed staff to administer medications as ordered by the physician. The care plan lacked identification and monitoring of black box warning medications.</p> <p>Review of a pharmacy consultant drug regimen review dated 9/3/2015 documented the clinical record was reviewed and there were no new suggestions.</p>	F 428			

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F 428	<p>Continued From page 70</p> <p>Review of the September 2015 MAR (medication administration record) documented staff held Lisinopril (a medication to treat high blood pressure) on 9/14/2015 and 9/15/2015.</p> <p>A review of physician ordered medications 8/26/2015 included the following medication orders: Cymbalta (a medication to treat depression) 60 mg (milligrams), give 120 mg by mouth daily for fibromyalgia (disease with chronic pain), effective 8/26/2015 Ferrous Sulfate (an iron supplement) 325 mg by mouth daily for anemia, effective 8/27/2015 Hydrocodone-Acetaminophen (a narcotic pain medication) 5-325 mg by mouth every 4 hours as needed for pain scale of 1-5, give 2 tablets by mouth every 4 hours as needed for pain scale of 6-10, effective 8/26/2015 Lisinopril 20 mg, give 40 mg by mouth BID for hypertension, effective 8/26/2015 Lovenox (a medication used to prevent blood clots) 40 mg/0.4 ml (milliliter), give 40 mg subcutaneous daily for clot prevention, effective 9/13/2015 Synthroid 150 mcg (micrograms) by mouth daily for hypothyroidism (low thyroid hormone), effective 8/26/2015 Trazodone (an antidepressant) 75 mg by mouth every bedtime for insomnia (inability to sleep), effective 9/9/2015</p> <p>During an observation on 09/17/2015 at 9:30 A.M. the alert and oriented resident sat in his/her electric wheelchair and worked with therapy.</p> <p>During an observation on 09/17/2015 at 4:32 P.M. the alert and oriented resident worked with therapy in the therapy room.</p>	F 428			

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F 428	<p>Continued From page 71</p> <p>During an interview on 09/21/2015 at 1:58 P.M. the resident said he/she was not aware if staff held his/her blood pressure medication, but he/she wanted staff to notify him/her "because I need to know that too". The resident stated he/she did not have negative effects from his/her medications.</p> <p>During an interview on 09/17/2015 at 11:21 A.M. direct care staff S stated direct care staff communicated behaviors verbally to the charge nurse. Staff S said CNA's (certified nursing assistants) documented bowel movements and vital signs. He/she said once he/she documented vital signs he/she gave the list to the charge nurse.</p> <p>During an interview on 09/17/2015 at 2:49 P.M. direct care staff T stated he/she was not aware if staff documented behaviors. He/she said if a resident experienced behaviors, he/she let the nurse know.</p> <p>During an interview on 09/21/2015 at 10:42 A.M. direct care staff Q said if a resident's blood pressure was more than 110/52, he/she let the nurse know immediately, otherwise he/she gave the vital sign flow sheet to the nurse once staff obtained all the vital signs.</p> <p>During an interview on 09/21/2015 at 1:04 P.M. licensed nursing staff H stated staff held blood pressure medications based on nursing judgment and the nurse notified the physician and the resident. Staff H confirmed nursing staff held Lisinopril on 9/14/2015 for a blood pressure of 117/67 and on 9/15/2015 for a blood pressure of 108/49. Staff H confirmed the medical record</p>	F 428			

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F 428	<p>Continued From page 72</p> <p>lacked documentation of physician or resident notification of blood pressure results and nurse's decision to hold Lisinopril. Staff H confirmed the care plan did not address black box warning medications.</p> <p>During an interview on 09/21/2015 at 7:54 P.M. administrative nursing staff D said he/she expected staff to hold blood pressure medication if the resident's systolic blood pressure (top blood pressure number) was less than 100 and the diastolic blood pressure result (bottom number of blood pressure) was not considered. Staff D expected staff to notify the resident and the physician if a nurse held a medication and expected the nurse to document the communication. Staff D expected staff to identify and monitor black box warnings.</p> <p>During an interview on 9/24/2015 at 10:51 A.M. pharmacy consultant KK stated he/she visited the facility for medication reviews monthly and his/her last visit was on 9/3/2015. Staff KK said he/she was aware black box warning medications did not specify the warnings and he/she verbally communicated his/her concerns to the facility. Staff KK stated he/she did not have access to the electronic record at the facility and was not aware staff held blood pressure medications without a physician's order. Staff KK said he/she was aware there were no parameters for blood pressures.</p> <p>The facility failed to provide a pharmacy services policy as requested.</p> <p>The pharmacy failed to monitor and make recommendations of warning medications for this resident with physician prescribed black box warning medications and failed to monitor and</p>	F 428			

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F 428	<p>Continued From page 73</p> <p>make recommendations for blood pressure parameters for holding this resident's physician prescribed blood pressure medication on 2 occasions.</p> <p>- Review of resident #93's signed physician order sheet dated 9/2/2015 documented the following diagnoses: pneumonia (inflammation of the lungs) and hypertension (elevated blood pressure).</p> <p>Review of the admission MDS (Minimum Data Set) dated 9/7/2015 documented a BIMS (Brief Interview for Mental Status) score of 13, which indicated the resident had intact cognition. The resident required limited assistance of one with toileting. The resident received 7 days of antidepressants and 7 days of antibiotic medication during the 7 day observation period.</p> <p>Review of the Psychotropic CAA (Care Area Assessment) dated 9/10/2015 documented the resident received antidepressant medication and staff were to monitor for signs/symptoms of side effects.</p> <p>Review of the care plan dated 8/31/2015 lacked documentation of black box warnings, behavior monitoring for medications effectiveness of antidepressant use. The resident had a risk for altered elimination and staff were to administer medications as ordered, keep an accurate record of bowel movements to avoid complications, and to assist to utilize the toilet as needed.</p> <p>Review of a pharmacist drug regimen review dated 9/3/2015 documented the resident should take Ibuprofen with food.</p>	F 428			

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F 428	<p>Continued From page 74</p> <p>Review of a bowel movement monitoring record dated 8/31/2015 to 9/20/2015 documented the resident had no bowel movements from 9/3/2015 through 9/8/2015.</p> <p>Review of the MAR (medication administration record) dated 9/3/2015 through 9/8/2015 documented the resident received no additional medications for bowel regulation.</p> <p>Review of nursing progress notes dated 9/3/2015 through 9/8/2015 documented the resident had a bowel movement on 9/6/2015.</p> <p>Review of physician orders included the following medications: Dulcolax (a medication to treat constipation) 10 mg suppository rectally daily as needed for bowel regulation, effective 9/3/2015 Oxycodone/Acetaminophen (a narcotic pain medication) 5-325 mg, give 2 tablets every 4 hours as needed for pain rated a 6-10, effective 8/31/2015</p> <p>During an observation on 09/16/2015 at 5:21 P.M. the resident laid in his/her bed with eyes closed, lights out, and no signs of restlessness.</p> <p>During an interview on 09/16/2015 5:43:04 P.M. the resident stated he/she was aware of his/her medications, he/she received the same medication for some time, and had no negative effects from his/her medications.</p> <p>During an interview on 09/21/2015 at 1:45 P.M. the resident reported he/she experienced constipation since admission. The resident said he/she told staff and staff said they would give him/her medication to treat the constipation, but staff did not.</p>	F 428			

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F 428	<p>Continued From page 75</p> <p>During an interview on 09/17/2015 at 11:21 A.M. direct care staff S said staff monitored and documented bowel movements and vital signs daily.</p> <p>During an interview on 09/21/2015 at 10:36 A.M. direct care staff Q stated residents were asked in the mornings and later in the day when his/her last bowel movement occurred. Staff Q said staff documented bowel movements on the vital sign sheet and in the electronic record.</p> <p>During an interview on 09/21/2015 at 12:43 P.M. licensed nursing staff H stated the CNA's (certified nursing assistants) were to ask the residents when his/her last bowel movement was and document the bowel movements. He/she stated the nurse also documented in the progress notes if a resident had a bowel movement. Staff H said if a resident went 3 days without a bowel movement, the nurse administered Milk of Magnesia, if 4 days passed without a bowel movement, the nurse administered a Dulcolax Suppository, and if 5 days passed with no bowel movement, the nurse gave the resident an enema. Staff H confirmed the resident had no documented bowel movement from 9/3/2015 through 9/5/2015 and staff did not administer Milk of Magnesia. Staff H confirmed he/she was not aware of black box warning medications, said black box warning medications were not specific, and staff did not monitor potential negative effects for this resident.</p> <p>During an interview on 09/21/2015 at 7:23 P.M. administrative nursing staff D said he/she expected nurses and CNA's to document bowel movements. Staff D confirmed the resident had no documented bowel movement from 9/3/2015</p>	F 428			

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F 428	<p>Continued From page 76</p> <p>through 9/5/2015 and said the staff failed to administer Milk of Magnesia to the resident on 9/5/2015. Staff D confirmed staff did not care plan or monitor black box warnings. During an interview on 9/24/2015 at 10:51 A.M. pharmacy consultant KK stated he/she visited the facility for medication reviews monthly and his/her last visit was on 9/3/2015. Staff KK said he/she was aware black box warning medications did not specify the warnings and he/she verbally communicated his/her concerns to the facility. Staff KK stated he/she did not have access to the electronic record at the facility and was not aware staff held blood pressure medications without a physician's order and failed to treat for constipation. Staff KK said he/she was aware there were no parameters for blood pressures.</p> <p>The facility failed to provide a pharmacy services policy as requested.</p> <p>The pharmacy failed to monitor and make recommendations to the facility for this constipated resident and failed to monitor and make recommendations to the facility for physician ordered black box warning medications.</p> <p>- Review of resident #259's signed physician order sheet dated 9/15/2015 documented the following diagnoses: chronic obstructive pulmonary disease (chronic poor airflow in the lungs) and hypertension (elevated blood pressure).</p> <p>The MDS (Minimum Data Set) and the CAA (Care Area Assessment) were not completed because the length of stay criteria was not met.</p>	F 428			

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F 428	<p>Continued From page 77</p> <p>Review of the care plan dated 9/14/2015 revealed staff did not address medications.</p> <p>Review of the September 2015 MAR (medication administration record) documented the following: On 9/17/2015 Coreg 6.25 mg by mouth staff did not administer. Staff documented the resident's blood pressure was low at 109/67.</p> <p>On 9/19/2015 Coreg for a blood pressure of 99/62, staff held the medication.</p> <p>Review of physician orders documented the following: Coreg 6.25 mg (milligrams) by mouth twice daily with meals for hypertension, effective 9/14/2015</p> <p>During an observation on 9/17/2015 at 11:35 A.M. the resident sat in his/her recliner. The resident was alert, oriented, and anxious about his/her medications.</p> <p>During an interview on 09/17/2015 at 8:11 A.M. the resident said staff failed to give him/her Coreg.</p> <p>During an interview on 09/21/2015 at 2:13 P.M. the resident stated the nurse told him/her on 9/18/2015 that his/her blood pressure ran low and the physician chose to hold the evening dose of Coreg .</p> <p>During an interview on 09/17/2015 at 11:21 A.M. direct care staff S said CNA's (certified nursing assistants) obtain and document vital signs. He/she said staff documented all the vital signs,</p>	F 428			

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F 428	<p>Continued From page 78</p> <p>he/she gave the list to the charge nurse.</p> <p>During an interview on 09/21/2015 at 10:42 A.M. direct care staff Q said if a resident's blood pressure was more than 110/52, he/she let the nurse know immediately, otherwise he/she gave the vital sign flow sheet to the nurse once staff took all vital signs.</p> <p>During an interview on 09/21/2015 at 3:57 P.M. licensed nursing staff H stated he/she informed residents when he/she held a medication and was not aware if this was a facility policy. Staff H said the nurse should notify the physician if a nurse held a medication. Staff H confirmed staff held the resident's Coreg on 9/17/2015 for a blood pressure of 109/67 and held it on 9/19/2015 for a blood pressure of 99/62. Staff H said different staff held blood pressure medications for different blood pressure results and confirmed the medical record lacked documentation of physician notification of blood pressure results, late administration of breathing treatments, and holding of blood pressure medication.</p> <p>During an interview on 09/21/2015 at 7:54 P.M. administrative nursing staff D said he/she expected staff to hold blood pressure medication if the resident's systolic blood pressure (top blood pressure number) was less than 100 and the diastolic blood pressure result (bottom blood pressure number) was not considered. Staff D expected staff to notify the physician if a nurse held a medication and expected the nurse to document the communication.</p> <p>During an interview on 9/24/2015 at 10:51 A.M. pharmacy consultant KK stated he/she visited the facility for medication reviews monthly and his/her last visit was on 9/3/2015. Staff KK said he/she</p>	F 428			

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F 428	<p>Continued From page 79</p> <p>was aware black box warning medications did not specify the warnings and he/she verbally communicated his/her concerns to the facility. Staff KK stated he/she did not have access to the electronic record at the facility and was not aware staff held blood pressure medications without a physician's order. Staff KK said he/she was aware there were no parameters for blood pressures.</p> <p>The facility failed to provide a pharmacy services policy as requested.</p> <p>The pharmacy failed to monitor and make recommendations to the facility for blood pressure parameters and holding of this resident with hypertension physician prescribed blood pressure medication on 2 occasions.</p> <p>- Review of resident #242's signed physician's orders dated 9/1/15 documented the following diagnoses: congestive heart failure (the heart cannot pump enough blood to meet the body's need) and depression (feelings of sadness, worthlessness, and emptiness).</p> <p>Review of the 14 day admission Minimum Data Set (MDS) dated 8/31/15 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident did not reject cares. The resident received scheduled pain medication, an antidepressant, and a diuretic for 7 of 7 days during the 7 day observation period.</p> <p>Review of the Psychotropic Drug Use Care Area Assessment (CAA) dated 9/1/15 documented review of the resident's medications revealed they met the resident's needs, and staff continued to give medications as ordered and monitored for</p>	F 428			

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F 428	<p>Continued From page 80 adverse effects.</p> <p>Review of the care plan dated 8/19/15 directed staff to administer medications as ordered, monitor for pain, and notify the physician if the medication was not effective. Staff revised the care plan on 9/7/15 to address the resident's mood. The care plan directed staff to provide reassurance and support, monitor for withdrawal or increased depression, and to offer counseling services as needed. The resident was at risk for dehydration (not enough body water) due to medication use and staff to monitor labs as ordered and monitor for signs/symptoms of dehydration.</p> <p>Review of the resident's physician ordered medications included the following: Furosemide/Lasix (medication to treat increased body fluid) 20 mg (milligrams), give 40 mg once daily by mouth for edema, effective 8/19/2015 Sertraline (antidepressant) 100 mg by mouth once daily for depression, effective 8/19/2015 Spironolactone (medication to treat increased body fluid) 25 mg once daily for congestive heart failure, effective 8/19/2015 Levaquin (antibiotic) 500 mg, give 2 tablets daily for infection, effective 9/4/2015</p> <p>Review of a pharmacy review dated 9/3/2015 recorded no recommendations.</p> <p>During an observation on 9/16/15 at 3:30 P.M. the resident sat in his/her room calmly watching television.</p> <p>During an observation on 9/21/15 at 10:45 A.M. the resident sat in a recliner in his/her room. The resident was pleasant and cheerful.</p>	F 428			

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F 428	<p>Continued From page 81</p> <p>During an interview on 9/21/15 at 10:45 A.M. the resident stated he/she received his/her medications on time.</p> <p>During an interview on 9/21/15 at 2:09 P.M. licensed nursing staff H stated the resident had no behaviors, which required redirection. He/she said the resident received a medication for depression and was unaware of any other black box warning medications (high risk medications).</p> <p>During an interview on 9/21/15 at 6:51 PM licensed nursing staff M said the resident had no behaviors and he/she received 4 medications with black warnings and the warnings were in the narcotic book as of today.</p> <p>During an interview on 9/21/2015 at 7:54 P.M. administrative nursing staff D said he/she expected staff to care plan and monitor black box warning medications.</p> <p>The facility failed to provide a pharmacy service policy as requested.</p> <p>The pharmacy failed to monitor black box warning medication and make recommendations to the facility for this resident with physician prescribed black box warning medications.</p>	F 428			
F 441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control</p>	F 441			

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F 441	<p>Continued From page 82</p> <p>Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 29 residents. Based on observation and interview the facility failed to properly clean a resident's room and provide a sanitary environment to help prevent the development and transmission of disease and infection.</p> <p>Findings Included:</p>	F 441			

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F 441	<p>Continued From page 83</p> <p>- During an observation on 9/17/2015 at 12:39 P.M. housekeeping staff Z stated he/she was not aware of the specific isolation precautions for the room he/she cleaned. At 1:39 P.M. staff Z sprayed the bathroom floor with disinfectant cleaner and immediately wiped the floor using his/her foot and a dry cloth.</p> <p>During an interview on 9/17/2015 at 1:42 P.M. housekeeping staff Z stated he/she was not aware how long the disinfectant should remain on the floor before wiping.</p> <p>During an review of the disinfectant bottle, the label revealed the staff should spray the surface until completely wet and let stand for one minute, wipe with a clean cloth, damp cloth, or paper towel or allow to air dry.</p> <p>During an interview on 9/17/2015 at 1:53 P.M. administrative staff A stated he/she expected staff to follow the manufacturer's instructions.</p> <p>Review of the facility's undated Contact Precautions policy documented in addition to Standard precautions, the facility used Contact Precautions for specific residents known or suspected to be infected.</p> <p>The facility failed to follow manufacturer recommendations to clean the room of a resident on contact isolations precautions.</p>	F 441			